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THE EROSION OF THE MEDICARE HOME HEALTH CARE BENEFIT

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

NEWARK, NJ

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THE EROSION OF THE MEDICARE HOME HEALTH CARE BENEFIT

MONDAY, APRIL 21, 1986

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Newark, NJ.

The committee met, pursuant to notice, at 9:15 a.m., in room 2132, Essex County College, Newark, NJ, Hon. Bill Bradley presiding.

Present: Senators Bradley and Lautenberg.

Also present: Kenneth Apfel, legislative assistants and Ray Bramucci, State director for Senator Bradley's office.

OPENING STATEMENT BY SENATOR BILL BRADLEY, PRESIDING

Senator BRADLEY. This is a field hearing of the U.S. Senate Special Committee on Aging. I requested this hearing to solicit testimony from the Medicare recipients and health care providers on the Medicare home health care benefit. Many New Jerseyites have indicated that the Health Care Financing Administration, through a variety of administrative mechanisms, is squeezing down on the level of home care services reimbursed through Medicare. I am holding this hearing today to get the facts straight on this matter.

We are all too aware that the present system of Medicare reimbursement for home care is totally geared toward post-acute care rather than long-term care. For many years, I have tried to get the Senate to focus on the need to expand home care services to include long-term care. And I am not going to give up that fight. But we cannot forget the importance of strengthening and protecting the post-acute care Medicare home care benefit as well.

In 1983, in an attempt to control rapidly increasing hospital costs, Congress enacted a new prospective method utilizing so-called Diagnostic Related Groups, or DRG's, to reimburse hospitals for their care of Medicare patients. The DRG system provides an incentive for hospitals to reduce the length of a hospital stay to only that period of time where a patient requires acute care. This means that some people leave the hospital sicker and quicker than in the past.

There is nothing wrong in reducing the length of a hospital stay so long as a patient has access to a less intensive level of care after their stay in the hospital setting. Indeed, when services in hospitals are cut back, there is an obvious need to increase the availability of home care services to fill that gap. That is exactly what we have seen over the past few years, the proportion of patients leaving the

hospitals that are receiving home care services has expanded rapidly in recent years. But, today, there are new and disturbing trends. I have read reports that here in New Jersey there has been an actual reduction in the number of patients being accepted for home care and a significant increase in the number of patients being denied Medicare coverage for home care services. This hearing will examine those charges and determine if the elderly are receiving the health care services they need and deserve.

The Health Care Financing Administration has contracted with Prudential and Blue Cross/Blue Shield to handle the Medicare paperwork on home care. These intermediaries determine eligibility and make reimbursements on a case-by-case basis according to HCFA guidelines. I want to make clear that the focus of this hearing is not to examine whether HCFA's intermediaries have made individual mistakes in determining eligibility for home care benefits. We all know that mistakes can be made. What I want to find out is whether HCFA's policies are leading to New Jersey's elderly not getting the care they need and deserve.

If these hearings lead me to the conclusion that people with real needs are not being helped by Medicare, then I intend to propose legislation to establish tighter standards to better guide decisions about eligibility for home care services.

So this hearing will have several parts. We have a number of individual witnesses, and then we will have a consumers panel, a panel of the elderly who need home care services or whose family members need home care. Then we will have a panel of providers of health care.

Our first witness today is my colleague in the Senate, the other Senator from New Jersey, Senator Lautenberg.

Senator Lautenberg, we are glad to have you today, and you may proceed with your testimony. I know of your interest and concern for the elderly of New Jersey, and I think your presence here today illustrates that.

STATEMENT BY SENATOR FRANK R. LAUTENBERG

Senator LAUTENBERG. Thank you, Senator Bradley.

I am pleased to be here with you to testify before the Special Committee on Aging. You have been a leader in fighting to provide quality health care to our senior citizens. You have evidenced that concern in many ways. Your presence here today holding these hearings and your service on the committee, the Special Committee on Aging, your concern about home health care services is evident. And I think it is important that the people in New Jersey hear the remarks that will be presented here today in our own State to explore these problems.

With your permission, I would like to read an abbreviated version of a statement and submit the full text for inclusion in the committee hearing record.

As you know, many of our constituents face hardships because of the increasingly hard line taken by the Health Care Financing Administration which runs Medicare. Unfortunately, on the home health care issue, HCFA has played havoc with people's lives with no apparent bad conscience. Congress set the ground rules for Med-

icare programs, and HCFA must be responsive to the mandate of the Congress. Instead, on the home health care issue, HCFA has acted on its own to make policy and flout the will of the Congress.

The Medicare DRG system is encouraging hospitals to discharge patients earlier than in the past. And you made the comment, Senator Bradley, that people often refer to this as discharging quicker and sicker. Many of these patients require home health care to assist them in the transition from acute hospital care, but HCFA is attempting to cut back its reimbursement for home care.

The patients are placed in a kind of a no man's land. The hospitals cannot keep them; they cannot get care at home either. Surely this is not the way that Medicare should be treating its elderly beneficiaries.

In New Jersey, claims denials for home health care increased 27 percent in 1985. The number of admissions to home health care services have decreased for the first time in 10 years. These trends are disturbing. These same trends are apparent nationally.

Is this a sensible policy? Is Medicare saving a lot of money by cutting back on home health care reimbursement? Is home health care an extravagant service? The answer to all these questions is an emphatic no.

Home health care accounts for about 3 percent of the $49.2 billion Medicare part A budget for 1986, 3 percent. It is certainly not a major cost factor for the program.

Home health care is a cost-effective service. Adequate home health care keeps patients from returning to the hospital or having to enter nursing homes. With the availability of home care, hospitals can more comfortably discharge patients when they still require attention but not acute hospital care. Certain long-term services can be provided at less expense, and with more comfort often, than they would get in the hospital.

But HCFA says no to an increasing number of these services. HCFA, no doubt, under pressure from OMB, would rather save money today than worry about the well-being of Medicare's elderly clients. And HCFA seems to have no concern with the fiscal consequences of its policies which will lead to spending more money tomorrow. This perspective is very shortsighted.

The Acting HCFA Administrator has indicated a determination to continue to tighten the rules for home health care reimbursement. Now, I share the goal of trying to hold down Medicare costs. But he has chosen a strange way to do it. Money can be saved if HCFA refused to pay for certain services. But that is an artificial way to control costs. It does nothing to contain cost increases or reduce the demand for services. It saves money for Medicare, but shifts the burden to other payers.

The tragic results, all too frequently, are that the patients have to do without health home care services. And then the patient just gets sicker. Ultimately, no money is saved. And valuable human resources are wasted. The comfort, caring, and security that a senior citizen deserves are shattered. And the human cost is very high.

Nor is the tighter rein on home health care the only example of HCFA striking out on its own in a manner that is injurious to its beneficiaries. Unusual and disturbing delays are occurring in Medicare benefit payments. HCFA has apparently directed Medicare

carriers to extend processing time by 15 to 18 days on claims. This additional delay in the payment of Medicare claims causes a hardship for beneficiaries, is unfair to providers, and is not in the best interest of the program.

Now I could provide further examples. But I think the point is very clear.

HCFA is unilaterally making changes in Medicare rules that hurt the program, and particularly hurt the elderly beneficiaries. Twenty years ago, when Medicare began, the elderly were paying about 15 percent of their incomes for health care. As the benefits of Medicare took hold, out-of-pocket expenses dropped substantially to 12 percent of their income by 1977. This year the expenses that the elderly will have to pay for themselves will be back up to 16 percent.

Certainly one of the most dramatic and damaging changes that has been made in Medicare is the tightening up on home health care rules. I think HCFA is wrongheaded in this policy. The policy shows a lack of compassion. The policy does serious harm to elderly patients and, in the long run, it will not even save money.

Medicare must be restored to its promise for the golden years. And reversing the overly restrictive policy on home health care is the right place to start.

Senator Bradley, I have seen evidence of this. I have a mother who is 82 years old. Fortunately, she can afford to pay the difference between the costs that she is reimbursed for and those which are required. And she is at home. And I see respiratory therapists come by. And it just changes her life, it changes her ability to function. I am sure this is repeated in thousands of cases around our State and our country.

Medicare is a program that has worked. We see evidence of it. We see better health for our senior citizens. We see greater longevity. And for the life of me, I cannot understand why we are tinkering with programs that do work, have a proven record of effectiveness, and now are subject to arbitrary cuts and arbitrary decisions, again flaunting the will of the Congress in terms of its intention to provide the elderly with better health care and more security in their later years.

Medicare has got to be revitalized, as I know you and I agree. And I pledge myself to work with you and the full Committee on Aging on this vital issue. And once again I commend you for your interest and for holding this hearing and making certain that the senior citizens of New Jersey and across this country know that they have a champion on behalf of their health.

[The prepared statement of Senator Lautenberg follows:]

TESTIMONY BY SENATOR FRANK R. LAUTENBERG
SENATE SPECIAL COMMITTEE ON AGING
NEWARK, NEW JERSEY
APRIL 21, 1986

Senator Bradley, I am pleased to be here today to testify before the Special Committee on Aging. You have been a leader in fighting to provide home health care services. That is evident in this initiative, to hold a hearing in our state to explore problems in New Jersey surrounding the Medicare home health program.

As you know, many of our constituents face hardships because of the increasingly hard line taken by the Health Care Financing Administration, which runs Medicare. Unfortunately, on the home health care issue, HCFA has played havoc with people's lives with no apparent bad conscience. Congress sets the ground rules for the Medicare Program. HCFA must be responsive to the mandate of Congress. Instead, on the hhc issue, HCFA has acted on its own to make policy and flouted the will of Congress.

The Medicare DRG system is encouraging hospitals to discharge patients earlier than in the past. Some people refer to this situation as discharging "quicker and sicker." Many of these patients require home health care to assist them in the transition from acute hospital care. But HCFA is attempting to cut back its reimbursement for this home care.

The patients are placed in a kind of no-man's-land. The hospitals cannot keep them, but they cannot get care at home either. Surely this is not the way that Medicare should be treating its elderly beneficiaries.

In New Jersey, claims denials for home health care increased 27% in 1985. The number of admissions to home health care services have decreased for the first time in ten years. These trends are disturbing.

These same trends are apparent nationally. A survey by the National Association of Home Care tells this story:

* Almost all home health care agencies reported a sharp increase in the proportion of very sick patients requiring intensive nursing care.

* Three quarters of the agencies said that large numbers of citizens were not receiving the home care services they need.

* Two-thirds of the agencies found that there was a significant increase in the number of claims denied by Medicare in the last year.

Is this a sensible policy? Is Medicare saving a lot of money by cutting back on home health care reimbursement? Is home health

care an extravagant service? The answer to all these questions is an emphatic, "No."

Home health care accounts for about 3% of the $49.2 billion Medicare (Part A) budget for 1986. It is certainly not a major cost factor for the program.

Home health care is a cost-effective service. Adequate home health care can keep patients from returning to the hospital or having to enter nursing homes. With the availability of home care, hospitals can more comfortably discharge patients when they still require care, but not acute hospital care. Certain long-term services can be provided at less expense, and with more comfort, at home than in hospitals.

But HCFA says,"No" to an increasing number of these services. HCFA, no doubt under pressure from OMB, would rather save money today, than worry about the well-being of Medicare's elderly clients. And, HCFA seems to have no concern with the fiscal consequences of its policies, which will lead to spending more money tomorrow. This perspective is very short sighted.

The acting HCFA administrator has indicated a determination to continue to tighten the rules for home health care reimbursement. I share this goal of trying to hold down Medicare costs. But, he has chosen a strange way to do it. Money can be saved if HCFA refuses to pay for certain services. But that is an artificial way to control costs. It does nothing to contain cost increases or reduce demand for services. It saves money for Medicare, but shifts the costs to other payers.

The tragic result, all too frequently, is that the patient has to do without home health care services. And, then the patient just gets sicker. Ultimately, no money is saved. And valuable human resources are wasted. The comfort, caring, and security that a senior citizen deserves are shattered. The human cost is very high.

Nor is the tighter rein on home health care the only example of HCFA striking out on its own in a manner that is injurious to its beneficiaries. Unusual and disturbing delays are occurring in Medicare benefit payments. HCFA has apparently directed Medicare carriers to extend processing time by 15 to 18 days. This additional delay in the payment of Medicare claims causes a hardship for beneficiaries, is unfair to providers, and is not in the best interest of the program.

Many beneficiaries pay their physicians' bills in full, and wait for the reimbursement from Medicare. When that reimbursement is late in coming, elderly beneficiaries are put in a financial pinch. They are angry and upset about this deterioration in service. And their anger is justified.

Providers are finding that long delays in receiving payment affects their ability to serve elderly patients. Home health care agencies and other providers are experiencing severe cash flow problems as a result of these delays. The ability of some to remain

in operation is in jeopardy. Like any service provider, health care professionals should not encounter excessive delays in receiving payment.

I could provide further examples. But the point is clear. HCFA is unilaterally making changes in Medicare that hurt the program, and particularly hurt elderly beneficiaries. Twenty years ago, when Medicare began, the elderly were paying about 15 percent of their income for health care. As the benefits of Medicare took hold, out-of-pocket expenses dropped substantially to 12 percent of their income by 1977. This year the expenses that the elderly will have to pay for themselves will be back up to 16 percent.

Certainly, one of the most dramatic and damaging changes that has been made in Medicare is the tightening up on home health care. HCFA is wrongheaded in this policy. The policy shows a lack of compassion. The policy does serious harm to elderly patients. And, in the long run, it will not even save money.

Medicare must be restored to its promise for the golden years. And reversing the overly restrictive policy on home health care is the right place to start. I pledge myself to working with you and the full Aging Committee on this vital issue.

Again, I commend your longstanding interest and leadership on home health care issues. I appreciate the opportunity to be here today.

Senator BRADLEY. Thank you very much for your testimony and particularly for you calling attention to the damage that the delay in the Medicare reimbursement creates for agencies as well as beneficiaries. And I thank you for your continued support of efforts to improve the quality of home health care and to make good on the promise of Medicare to our senior citizens in New Jersey and across the country.

Thank you very much for coming.

Our next witness will be Geoffrey Perselay, commissioner of the New Jersey Department of Human Services.

Welcome to the Committee on Aging, Commissioner Perselay. Please begin with your testimony.

STATEMENT OF GEOFFREY PERSELAY, ACTING COMMISSIONER, NEW JERSEY DEPARTMENT OF HUMAN SERVICES

Mr. PERSELAY. Thank you, Senator Bradley.

Before I start into my testimony, I would like to take a few minutes—and I know that you are under a time restriction—but I would just like to thank you on behalf of the department of human services and all of the clients that we serve, not only for having this hearing but specifically for the major, major leadership role which you took in getting that reconciliation bill through the Congress, and for including some very, very special provisions in there which have saved many programs in this State: The AFDC Homemaker Program, which is not necessarily unique to this State, but terribly significant to this State, as well as the new flexibility in the waivers and the case management services being included as optional State service in the Medicaid Program are very, very significant, and go an awful long way toward expanding our ability to deal with people at home in their community. And I would certainly like to commend you for all the actions and leadership that you took in that regard.

Senator BRADLEY. Thank you, Commissioner. It is always good to hear praise.

Mr. PERSELAY. Senator, my name is Geoffrey Perselay. I am the acting commissioner of the New Jersey Department of Human Services. And I really would like to thank you for providing us with the opportunity to speak about the problems that we are having with the Medicare cutbacks.

I will focus this morning on the Medicare cutbacks in home health care which are especially serious in the context of the national effort to reduce hospital utilization.

We believe in New Jersey that New Jersey's carefully designed diagnosis related groups hospital payment system is an effective and benign one. However, in order to remain effective, any DRG system must be combined with an equally effective system of home care. For DRG's to be both cost beneficial and ethical, there must be a good network of sophisticated home health care to which patients can be discharged. If patients leave the hospital earlier and sicker, we must ensure that they can receive appropriate followup care at home. For the elderly, the principal source of this postacute home health care is the Medicare Program.

We have a good deal of evidence, Senator, that an intensive effort has been made by the Health Care Financing Administration to make major reductions in Medicare home health benefits through unwarranted and unannounced reinterpretations of long-standing statutory and regulatory language.

It appears that the Health Care Financing Administration has directed its fiscal intermediaries to force cutbacks in home health care costs by shifting those costs to providers, to the States, and to the infirm themselves.

To address this situation, I met with officials of HCFA and of Prudential, New Jersey's fiscal intermediary, to discuss the recent reinterpretations and resulting denials of payment.

Unfortunately, that meeting did not enlighten us as to the rationales for changing the definitions used to deny benefits. Those definitions would include "home bound" and "intermittent care." We have collected data on numerous specific cases where home care was clearly needed and appeared fully justified based on Medicare's published rules. However, the intermediary's response to these cases was denial, denial based on arbitrary and, in some cases, inconsistent rulings and technicalities.

HCFA and the intermediaries have not been willing to publish for comment and review their guidelines for interpreting the rules, which have always been extremely vague and, therefore, subject to a wide range of interpretation. We are convinced that there is no case, real or hypothetical, that could not be denied by the intermediary, based on one of the arbitrary and senseless reasons currently being given to provider agencies. This sort of ad hoc denial of individual cases does not reduce the overall costs of care by reducing overuse of service by those who do not need it. That we could support. Instead, it leads to denial of care to some of the sickest individuals, with the highest care needs, and no alternative care available.

Our proposed solutions to end this intolerable situation center on actions at both the Federal and State levels. We strongly support efforts of our congressional delegation, such as this hearing, to lead efforts toward legislative reform of HCFA's policies.

In addition, we are currently working with the State department of the public advocate, which is unusual, in this State. So we are working with the department of the public advocate and the division on aging to develop a "program of legal assistance for medicare patients" or "LAMP," as we call it. The LAMP program would be one where attorneys would appeal Medicare denial of care. Other States have had great success with such legal initiatives, and have been both financially and morally victorious in hearings before administrative law judges.

I think the importance of that last option in terms of LAMP cannot be understated because we feel very strongly that what is happening now with HCFA is very, very similar to the unauthorized cutbacks that occurred a few years back when the Social Security Administration tried to unilaterally redefine the word "disabled." That cruel attempt at purging the Social Security system of thousands of totally and tragically disabled persons was, as we all know, defeated through the joint efforts of forceful elected officials such as yourself, a vigilant press, and an outraged public.

It is our hope that strong support in Congress for a comprehensive Medicare home health benefit will prevent continued cost-shifting to the States and denial of needed care by Medicare beneficiaries.

Thank you.

Senator BRADLEY. Thank you very much for your cooperation with my office on this matter, as well as many others. I think it would be important to note whether you agree that if Medicare does not pay for some of the home care benefits, as it is now failing to do in many cases, the costs could fall to Medicaid. Is that not correct?

Mr. PERSELAY. There is a whole host of—what we have in the State of New Jersey is a very comprehensive matrix of services available for home care. And if I could just read off a few.

The community care waiver for the elderly and disabled; this Medicare program; personal care program; the Medicaid model waivers which we have had three model waivers; the Respite Care Program which we have State funded; the Peer Grouping Program which we are starting to initiate; the AFDC Homemaker Program. All of these are programs which are mixing and matching and putting together to provide a comprehensive home care system to the elderly in this State.

The impact of Medicare cutting back would have an impact on all of these programs and put a drain on those resources.

Senator BRADLEY. Under the guidelines of Medicare, home care is provided for 3 days a week.

Now, I have heard, and I wonder if you could confirm this, that there are senior citizens in the State who are being denied any coverage if the person needs 5 days of care and is willing to pay for 2 of those days himself of herself. It appears that individuals are being denied the 3 days that normally would be covered under Medicare, is that correct?

Mr. PERSELAY. It is ludicrous. Traditionally, Medicare looked at the 3 days and utilized or followed the funding source that they had.

Now, under this reinterpretation, which has not been published, Medicare is now looking at the total source of funds that goes to providing home care for the elderly. If the total fund source pays for more than 3 days, they will then take a look at that and call that continuous care, not intermittent care. And they cut back or they deny the Medicare benefits.

I have done some examples that we have. I would like to submit most of these for the record. But I think that if I were able to read like one which would give a definition of intermittent care, it is a case where a 73-year-old man had a stroke and was completely disabled and confused. He had deep bed sores on his right heel and his back. Although his wife cared for him, changing the dressings was beyond her ability and required nursing care.

In August, the intermediary called the agency and informed that the payment was denied back to January 1. The intermediary stated that the care was continuous, not intermittent, and that the client should be in a nursing home. However, the client did not qualify for nursing home care under Medicare.

Now, if you take a look at—they are taking a look at all the sources that go together, they are ruling out the intermittent services because of the total sources that provide for a comprehensive period of time in home care to keep that individual out of a nursing home and more expensive care.

It is a cruel decision. It is a hoax on the elderly as far as I am concerned.

Senator BRADLEY. That is one example, that brings it home to all of us. And I think we will hear more examples in the course of the hearing. I think that it is not only cruel but it is mindless.

Before you go, could you tell me the status of the New Jersey Homemaker/Home Health Aid demonstration?

Mr. PERSELAY. Alive and well. And we have done very well with it.

Over the last couple of years, we have trained over 800 welfare clients to provide homemaker health services. We look forward to continuing the program thanks to your great efforts on that.

Senator BRADLEY. I want to thank you for putting the operational part in to such good shape. It makes eminent sense to support a program if you can take people off of welfare and put them into a growth industry, which is, in my view, the home care area.

Mr. PERSELAY. When we started up the program, we had 50—this program is so beautiful—we had 50 job openings for home health care. And the myth of welfare clients not wanting to work, I just want to point out, for those 50 job openings, we had 750 applicants to get into the Home Health Aid Program.

So it is a program of people helping people. It is a growth opportunity for the clients, and it is a growth industry and it has been very, very successful.

Senator BRADLEY. Thank you for your testimony today and for your continued stewardship for the elderly in our State.

Mr. PERSELAY. Thank you, Senator.

Senator BRADLEY. Our next witness will be the county executive of Essex County, Peter Shapiro.

Welcome to the Aging Committee, Peter, and please feel free to go ahead with your testimony.

I know that you are a tireless worker for the elderly in Essex County and across the State of New Jersey.

STATEMENT OF HON. PETER SHAPIRO, COUNTY EXECUTIVE, ESSEX COUNTY, NJ

Mr. SHAPIRO. Thank you very much. And I would like to in turn welcome you to Essex County College, to this beautiful facility. I am glad to see the sound system working as well as it is.

Is this our sound system or your sound system.

Senator BRADLEY. I believe this is the Committee on Aging's sound system.

Mr. SHAPIRO. OK. Well, the walls are ours.

This is Essex County sound system? OK, good. I think we have got two competing sound systems, right.

Senator BRADLEY. I think that Essex County provides the sound system but we provide the recorder.

Mr. SHAPIRO. Oh, OK, very good. Very good. Because I can see two sets of sound guys out there. It is a little hard to tell.

Let me, though, welcome you here to this fine facility. I wish we could offer you sunnier weather, but it looks like they have saved that for the weekend alone.

I am glad to be here and glad that you brought the Senate Committee on Aging to Essex County for this hearing on Medicare home health care benefits.

Essex County has an important role to play in this because it is one of the largest single service providers of social services of any agency in the country because of the way county government is structured.

Since Medicare was enacted 20 years ago, there have been many great changes both in the people served by the program and in the care that they need.

Today, older adults comprise the fastest growing segment of our society. Here in New Jersey, statistics project that the number of people over the age of 85 will increase between 1980 and the year 2000 by 54 percent.

While the number of older adults is increasing—thanks in large measures to advances that have taken place in health care—the Medicare Program does not reflect the demographic changes which have taken place in our society. Nor does it reflect the changes that have taken place since economic and regulatory pressure has pushed hospitals and doctors to shorten hospital stays.

Commissioner Perselay already mentioned this in discussing New Jersey DRG Program, but this is really something which is going on throughout the country.

Getting people out of the hospital faster is basically a good idea. Given shorter hospital stays, however, older adults are coming home earlier in their recuperation and, as a result, need a greater level of care than they otherwise would.

For too many older adults, the recuperation period can become an interval of relapse before being readmitted to the hospital.

This happens for one reason. There is no appropriate level of home health care provided for a person of advancing years, even if that person is in generally frail health and comes home from a hospital in a weakened condition and is more vulnerable to complications.

There is no adequate home health care coverage for an older person who may very well be coming home to a spouse whose health is also failing or whose mobility is impaired.

For a person of over 85, in fact, the child someone may be depending on for help might be a senior citizen as well.

Common wisdom would be that with shorter hospital stays and an aging population, patients should be given better programs for aftercare. What they are receiving, instead, as you are hearing today, is a level of care that continues to worsen.

Medicare officials tell us otherwise. The Health Care Financing Administration insists Medicare has not been cut. "We are only clamping down on eligibility," they say.

Nonsense. Whatever the method, by out and out cuts or by more restrictive regulations, the result is the same. The number of Medicare recipients who are receiving home health care is decreasing.

And for those who are receiving care, the hours they receive have been severely curtailed.

The National Association for Home Care, last month, reported that the maximum coverage currently being reimbursed under Medicare appears to be 9 hours per week. Two years ago, 20 hours was not uncommon for a patient with a typical ailment.

A look at Medicare regulations tells a good part of the story:

First requirement: To be eligible for home care under Medicare, you must be ill enough to need skilled nursing care, but not ill enough to need a home health visit every day. You must need only what Medicare terms "intermittent care."

Of the New Jersey Medicare recipients now receiving home health care, half are getting 6 hours or less a week. Remember, these are people who are not merely moderately ill. They are people whom Medicare itself recognizes needs skilled nursing care.

Take one of our residents, who I will call Mildred F. She is 80 years old, and was hospitalized with severe pneumonia. At the time of her discharge, she still had congestion in her lungs. Miss F lives alone in an apartment and requires assistance for all activities, including walking and eating. Her only relatives live in Illinois, and they were unable to care for her or provide her with support. Medicare authorized assistance of a home health aide for 4 hours a week. Within 1 week of her discharge, Mildred F was back in the hospital in major respiratory distress.

Second requirement: You must be homebound. Not just at home most of the time, but absolutely homebound. That means that if someone can be helped out of doors to sit on a park bench and get some fresh air, that person is ineligible for home health care under Medicare. So is a person who is able to be taken to a center for kidney dialysis.

Third requirement: The care rendered must be deemed "reasonable and necessary and be prescribed by a doctor." This in itself does not sound bad, but the vagueness of the requirement has enabled Federal bureaucrats to disqualify care for many people in need. Social Security disability stories are a similar tale. Let me give an illustration on this one.

A 70-year-old county resident, who I will call Anna L, lives alone in senior citizen housing. She is diagnosed as being terminally ill with uterine cancer. She weighs 80 pounds. She is too weak to walk, even with assistance. Her only child lives in Wisconsin and cannot help care for her. Her case was referred to Medicare, which authorized a home health aide for her for 2 hours a day, twice a week. As a result, she is failing to get adequate nutrition, and her condition is going rapidly downhill. From a humane viewpoint, she is not receiving the kind of care that would make her final days easier for her. From a taxpayer's perspective, without better care at home, she is likely to be in and out of expensive hospitals before she finally succumbs to her illness.

Medicare, enacted as the Health Care Program for older adults, fails to consider the fact that older people desperately need chronic care. The conditions that are addressed now are only the most acute. Yet, as hospital stays become shorter in duration, more demands are placed on extended care in outpatient settings, and especially on home health care.

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Home care is often critical to maintain the fragile health of an older person and avoid unnecessary hospitalization.

I cannot overemphasize the frustration and the anger that is currently being felt by providers and elderly alike as patient after patient is denied coverage or given so bare a minimum of help. People cannot understand why they are being denied coverage. Their needs are not subtle. Even an untrained nonprofessional can easily see that help is needed. Yet it is not adequately provided.

Local governments, county welfare agencies, area agencies on aging, community-based groups and service organizations, the direct service providers, have assumed responsibility for trying to respond in a humane way despite our shrinking resources.

Local agencies have been creative, establishing new networks of service and care to ensure that precious health care dollars are not wasted.

Innovative use of our resources works to provide nonmedical support services to ease the shortcomings of the Medicare Program where possible.

In Essex County, for example, we earmark $2.3 million of social service block grant funding for home care.

Part of this funds a program to assist 1,500 people here with household chores and shopping under what we call a home-friend program. Often this minimum level of care is enough to sustain an elderly person's independent living.

Another program provides a higher level of care through homemaker services for an additional 150 people.

Yet, for all the good success stories, there are also the sad ones. Three hundred people are on waiting lists for these two programs alone. And this is even after the fact that we intentionally fail to advertise the existence of these programs because we know the resources that we have fall so short, and we do not want to provide false hope to people. That waiting list would be much, much longer if, in fact, we advertised the program's existence.

Local governments, if they are creative and well-meaning, can stretch resources provided to them, but we cannot make up the difference when the Federal Government leaves a yawning gulf between existing human needs and the funding provided to pay for them.

Other than Medicare, there is no program to fill the home health care needs of all of our elderly.

The social services block grant, which I referred to, although its scope is broad, could not begin to match the Medicare cutbacks, especially when SSBG has already been cut and faces future cuts.

The Older Americans Act already was dealt a 4.5-percent cutback in funding as of March 1, and will likely sustain further reductions, while the ranks of the elderly continue to swell.

We do not need any new program. Medicare already has the administrative apparatus in place to enhance home health care through its existing structure.

It is important to emphasize that home health care under Medicare is not needed by the vast majority of people. Studies show that 80 percent of those who receive home care have that care provided and paid for by family members at no cost to the public. We are not talking about the proposals that would undermine the strength

of the American family or encourage people to abandon their older relatives. What we are talking about is our Government meeting a reasonable level of responsibility for the quality of life of its most vulnerable citizens.

Medicaid provides for home health care, but in order to qualify for it, people must have no more than $1,500 in savings. Is the alternative then for people with more savings to become impoverished so they will be eligible for Medicaid as welfare recipients? Are we to tell older people to do a turnabout and, after a lifetime of being productive and frugal, now that they are old, to totally complete their savings so they can be helped?

This is not the retirement that Americans should look forward to for their golden years.

Thank you very much.

Senator BRADLEY. Thank you very much, Peter, for your testimony.

I think that your testimony indicates an understanding of the problem in human terms and also where the real gaps are in the governmental system.

Do you think greater flexibility is needed in determining eligibility so that fewer people will fall through the cracks? Would that help you as your departments try to decide how to direct people to available services?

Mr. SHAPIRO. I would think that greater flexibility is one of the key things that we need on this.

You are going to hear later in testimony from some of our providers here in Essex County; in fact on that provider panel will be the director of our Division of Aging, Lois Hull. And she will be able to even give you some more insight on that beyond my own.

But, from our own point of view, part of the problem, always being on a local level, is the sense that the Federal Government officials too often are reading the details of rules and regulations rather than the human dimension of the problem.

Senator BRADLEY. Back in 1981, there was a study—and whenever we attempt to tell HCFA to slow down and to consider the human dimension, they always cite the 1981 study—that said that 27 percent of the people who get home care have questionable eligibility for Medicare coverage for home care. That has certainly not been your understanding your experience, has it?

Mr. SHAPIRO. That has not been our experience whatsoever. It has tended to be the case much more that people who need it are not getting it.

It would be worthwhile to have, if you could, to have some of these officials take you out in the field and try to find one of these people who is receiving home health care who does not need it, to look at the condition that the elderly are in who need this care. And look how far apart the gap is between what they truly need and what they are receiving today. We really should be doing far, far better than what we are doing.

Ask some of them to join us. Ask some of them to come out with us here locally and see the condition that the elderly that we are talking who are homebound, who are shut in, who have so little opportunity for any of the things that make life decent, whether it is

socialization, whether it is housekeeping in the home, whether it is decent nutritional opportunity, or just a little bit of care.

Senator BRADLEY. Thank you very much for your testimony. I think it was very helpful, and I am sure the whole committee will benefit from it.

Mr. SHAPIRO. Thank you for having us.

Senator BRADLEY. Our next witnesses, which comprise our first panel today, are consumers of home health care. The panel will be led by Edith Edelson of the New Jersey Health Care Coalition. And then Delores Higham from Mercer County on behalf of her mother, Helen Kennedy. And then Katherine Trimble of Bergen County. And then Mrs. Roy giving testimony for Mrs. Kelly, who is her mother.

So do we have room for everyone? I hope that you would take your position.

Let me welcome all of you to the Committee on Aging, and let me thank you for your interest and, in particular, let me thank Edith Edelson for her leadership here and for calling to my attention this growing problem.

STATEMENT OF EDITH EDELSON, CO-CHAIRPERSON OF THE NEW JERSEY HOME HEALTH CARE COALITION

Ms. EDELSON. Thank you Senator Bradley.

The coalition has asked for this hearing, and we are grateful to you for the opportunity to discuss an issue of growing significance for seniors and their families—the declining role of Medicare in the face of a growing need for home health care. We also appreciate Congressman Rinaldo's response to our call. He will conduct a study of the issue through the Government Accounting Office.

The organizations in our coalition represent seniors, labor, educators, home health care providers, health workers, disabled citizens, clergy, and community groups.

As can be seen by the broad representation, organizations have matured to the point where, instead of elbowing one another away from a shrinking pie of funding, they now join forces to expand the pie for all of us. The coalition is committed to the principle that quality health care is a right for all and not a privilege.

When we talk of home health care, we refer mostly to seniors and people with disabilities. While the Health Care Coalition is concerned with the health needs of Americans of all ages, we will limit our remarks to only one age group, those 65 and over.

Demographic studies reveal the rapid aging of our population. In New Jersey, the older population has been increasing five times faster than the overall State population, and the fastest growing segment is those 75 or older. It is estimated that by the year 2000, one of every seven New Jerseyans will be over 65. That is 14.7 percent.

What are we going to do about their needs? When our country was young, we focused our attention on the children. Their primary need was education, and so our government provided compulsory education. Now that so many of us are old, we expect our government to continue its commitment and to provide for our primary need which is health care.

Thanks to the wonders of the medical system and technology, people are living much longer. But with this come chronic conditions. We can adjust to these while still maintaining our independence, provided certain services are accessible and affordable. For chronic conditions, home health care is a vital service.

Can the elderly afford the full cost of it? According to the 1980 Census, Social Security is the major source of income of elderly people. Nationally, 20 percent of the elderly receive at least 90 percent of their income from Social Security, and 40 percent of the black elderly depend on Social Security to this extent. Nationally, 17.5 percent of elderly women and 10.4 percent of elderly men are poor. And then close to a quarter of all elderly Americans are near poor, 125 percent of poverty. So let us not walk around with the vision of a senior carrying golf clubs as the typical well-off senior portrayed repeatedly in published articles.

The elderly cohort is not homogeneous, and a large number of them cannot afford the health care they need. But one thing they all have in common is that sooner or later they will have to cope with chronic illnesses. And another thing that is characteristic of all older people under any health conditions is their fierce preservation of their independent living.

And here is where the administration and HCFA have formulated policies that undercut the reimbursement of home health care. Medicare is the primary health insurance for the elderly. For many it is their only health insurance. But Medicare concerns itself only with acute illnesses and skilled nursing. The rest are called custodial, and reimbursement is denied. That leaves a very big gap in caring for chronic illnesses.

We do not want to be warehoused. We do not want to be an intolerable burden to our children, many of whom are also old and in need of health services. And we are resolved not to tolerate policies that deprive us of our right to quality health care and independent living.

And so we must turn to Congress, our elected officials, to overcome the indifference of the executive branch of the Federal Government and to redefine Medicare coverage so as to provide appropriate care for the rapidly growing cohort of seniors. We dare not procrastinate. We must put home health care services in place now to care for our current needs and to be available for the increased future needs as well.

Senator Bradley, we look to you and to Senator Lautenberg for leadership in drawing up and passing appropriate legislation.

Thank you.

Senator BRADLEY. Thank you very much, Mrs. Edelson. [Applause].

Thank you for your testimony, and again for your leadership.

Let us now hear from Delores Higham from Mercer County, who is testifying on behalf of her mother, Helen Kennedy.

STATEMENT OF DELORES HIGHAM, HAMILTON SQUARE, NJ, ON BEHALF OF HER MOTHER, HELEN KENNEDY

Mrs. HIGHAM. That is correct.

Good morning, Senator. I want to thank you, first of all, for all you are doing for the senior citizens.

I am here on behalf of my mother, who is 79 years old, and is ill. She has uterus cancer and she has heart problems, and she has diabetes and she is blind.

Today, there is a videotape of her in her home. And I would like them to present to you first, and then I will comment on it after the video show.

Senator BRADLEY. Are we ready on the video?

[Videotape of in-home interview with Helen Kennedy shown.]

[Videotape interview with Mrs. Helen Kennedy by John Paul Marosy.]

Mr. MAROSY. Can you tell me how long have you lived in this neighborhood?

Mrs. KENNEDY. Fifty-six years.

Mr. MAROSY. In the same house?

Mrs. KENNEDY. Yeah.

Mr. MAROSY. And what were the health conditions that led up to your needing home health care?

Mrs. KENNEDY. Well, I had—I got sugar and arthritis and bad heart. And I have cancer and blind. I got blind. And I just needed some help. And I had trouble with my bladder. I couldn't hold my water, and I had to wear pads. And I'd sit right next to this bathroom half of the day and half of the night because just when that came on, it's bad enough. I was there for quite awhile.

And the doctor got back, and I had to go in the hospital for that. And I went to the hospital for bleeding. And I had two D&C's. I had two of them since the summer up to now, like, you know, like a couple of months ago I had two D&C's. And I have to go like every 4 or 6—between 4 and 6 months for checkups to see how my cancer business is making out.

And I can't go near the fire and, you know, I can't see to go out. Can't see television, can't read. And I listen to the news and stuff like that on television, but I can't see, you know, the television. I just see people moving around.

Mr. MAROSY. When were you receiving that home health care services?

Mrs. KENNEDY. In the last year, well, the last year I had this bleeding and it was bladder trouble, infection. And I had that. And they didn't know what was the matter with me. And they called the doctor and the doctor said rush her right to the hospital.

So, this last time, when they took me to the hospital, I didn't even know anything. I was going to a diabetic coma. And they took me to the hospital and I was there for quite awhile. And that was when my sugar was 800.

Mr. MAROSY. How did your sugar get to such a high level? Didn't the nurse help you, didn't the nurse help you to monitor the sugar level?

Mrs. KENNEDY. No. I wasn't doctoring for sugar. When I got this feeling or anything, just like I said, if they hadn't dropped me off from the nurse, she would have seen those symptoms coming on with me. I was feeling, you know, sick and dizzy and everything. But I had nobody coming here at all, you know, because I was on

the—well, they rushed me to the hospital, and this last time and my sugar was 800.

And I never doctored for sugar before that, you know, because I had to take the insulin. So I said, well, I don't have nobody to give me insulin and I cannot give it to myself.

Mr. MAROSY. Do you feel if the nurse had been coming in, maybe you wouldn't have had to go to the hospital that time?

Mrs. KENNEDY. No, because if the nurse was coming in and checking me like she was doing, I think she would have recognized, you know, you have to have a professional person to recognize things like that. I mean that's how I feel right now. I don't know whether that's anything or not.

But I feel if they didn't drop me off this last time, I think they dropped me off too soon.

Mr. MAROSY. Mrs. Kennedy, I have a final question.

If Senator Bradley was here now, what would you like to tell him?

Mrs. KENNEDY. Well, I think that they should provide some things and make people, old people stay in their own home and just allow them that little bit of help. That's the point that I'm getting at, you know, for people like me who don't need welfare, any of that stuff, that I can hold my own if they just allow—they give me this little help.

If we could stay in our own home and get that little bit of help, and for that, you know, that's the main thing I think. It's just like I said before, that people like me could stay in their own home, and that would be—and get that help, why I think they're better off than just dropping us all together and me spending all my money. And that's a lot of help, to have somebody come in and give me a bath, and to me. Well, I have to—and my money's gone.

[End of interview with Mrs. Kennedy.]

Mrs. HIGHAM. I think my mother has said it very clear, and there is not really much more for me to say, except let me explain to you one thing.

There was a period of time that mother was in the hospital and she was brought home. We had the visiting nurse come for about 5 weeks. Well, she certainly is not a person that is going to get better, that is for sure. But they declared, when they cut her off, that there was nothing more they could do for her.

Well, I think that within that time there was a lot they could have done for her. First of all, if, as mother said, if the visiting nurse had been coming to her in the period of 2 or 3 weeks that this sugar was coming on, they would have seen the symptoms.

Now, I am there 2 or 3 days a week and over the weekend. But again I am not a professional. And I just thought my mother was not feeling well and it was not good.

So, one day when she called me finally, and said I am really sick, we rushed down, and there she was, practically just not knowing her name, not knowing—she said where am I? And at that point I knew that I had to get her to the hospital.

My husband and I took her out to the car, and it was pouring rain. And I do not mean just rain, pouring rain.

Now, can you imagine me trying to manage a 270-pound lady practically in a diabetic coma, putting her into a car? If we had

had the nurses at that time before she got that bad, the nurse would have recognized the symptoms, and she may not even had to go to the hospital. The doctor would have provided medication.

But, anyway, we got her into the car with great difficulty. As a matter of fact, she fell. Senator, how would you like to see your mother in the gutter? It was pouring rain, it was an awful experience. But, anyway, we finally got her to the hospital, and her blood sugar was 800. The doctor did not believe it. He took it three times. He said I do not believe this. He said she should be in a diabetic coma.

Well, whatever, they got it under control, and now my mother is home. Again they cut her off from the visiting nurse coming to check her out. And as we told you, she has sugar, she has heart problems, she has uterus cancer which cannot be operated on because of her heart and her weight, and she is blind.

Now, you tell me, Senator, does she need help or does she not?

Yes, we do have someone come in and bathe her a couple of days a week. But myself, I do the cooking, and my mother helps herself too. And again, it is unfortunate, but, you know, everybody—and I do not care who they are—has the right to decent health care.

So, again, we are appealing to you and to Congress to try and do something about this Medicare. It is absolutely unbelievable. I just do not understand it all because it is all beyond me. I am not in with the paperwork. All I see is my mother and other elderly people.

I am not here on behalf of only my mother. I am here on behalf of all the senior citizens, and maybe it may be one of you out there too one of these days. We are all getting old; we do not get younger. That is for sure.

Senator BRADLEY. I thank you very much for sharing your very personal story with us. One of the purposes of this hearing is for me to be able to take back to other Senators the record of personal histories on this matter. When we are confronted with HCFA denying someone like your mother any kind of home health care on the grounds that she really does not fit their definition of needy intermittent care, then that is crazy. Your testimony is very helpful in giving us further material to counter their activities.

I would like to come back and ask questions. But I would like to go through the panel now, if we can.

Mrs. Katherine Trimble of Bergen County.

Mrs. Trimble, welcome to the Aging Committee and I am glad that you could take the time to come today. We welcome your testimony.

STATEMENT OF KATHERINE TRIMBLE, PARAMUS, NJ, CONSUMER OF HOME HEALTH CARE

Mrs. TRIMBLE. Thank you, Senator Bradley.

Can you all hear me?

During the first 2 weeks of a cast for a broken ankle, I had to go to the doctors for x rays. I was terrified of falling on my back steps. I did not know anything about a home therapist coming.

One day, my husband answered a knock on the door, and there was a therapist from Hackensack Medical Center. She assured me

in my fright that she would teach me how to overcome stair obstacle. She did. She was a God send.

I mentioned to her that in trying to get up from the toilet, my knee and hip were killing me, excruciating pain. The therapist recommended a plastic seat to raise the height of the seat. And I never knew such a help existed. It saved me and my hip from further pain.

The therapist watched as I used crutches and walker, was patient as I learned the proper use. My husband listened and watched as she taught me so that he would be able to help me better.

After 2 weeks, x rays had showed that the setting of my ankle was not correct and an operation necessary, pin and screw.

In the 2 weeks of the first cast and 6 weeks of the second cast, muscles could get very flabby. The therapist gave me a printed sheet of exercises to follow, which I faithfully did. She also clued me in on how to get the hospital therapy appointments started.

"Angel of mercy" is what I called the therapist who encouraged me, prodded me, and gave me such practical and knowledgeable advice and comforted me with her firm confidence.

Senator BRADLEY. Thank you very much, Mrs. Trimble.

Let me ask you, what would you have done if there had not been home care physical therapists?

Mrs. TRIMBLE. Well, I just would have been home scared to death. Because one does not expect to fall in a hole in just a split second and have your ankle broken. And never having had any experience with this before or known anybody who did personally, I just did not know what to do next. And I was terrified that I was going to hurt my ankle more some way or other.

Senator BRADLEY. So she provided you services that you needed during that particular time for a very specific purpose?

Mrs. TRIMBLE. Yes. She helped me overcome that extreme nervousness and fright that I had.

Senator BRADLEY. And were you surprised when this kind of care was available?

Mrs. TRIMBLE. Yes. I was just delighted, delighted with her.

Senator BRADLEY. Thanks very much.

Now, I would like to introduce Mrs. Roy who is appearing on behalf of her mother, Mrs. Kelly.

STATEMENT OF PATRICIA ROY, TURNERSVILLE, NJ, ON BEHALF OF HER MOTHER, AGNES KELLY

Mrs. ROY. Yes.

Senator BRADLEY. Mrs. Roy, where do you and your mother live?

Mrs. ROY. In Turnersville, NJ. And my mother, Agnes Kelly, you are going to see a tape of her, was diagnosed as having cancer of the larynx almost 4 years ago. At that time, they gave her 4 months to live.

I just want to briefly tell you what has happened. I mean I do not have a prepared speech. The situation here is like this lady, Mrs. Higham.

Roles have changed and I have now become the mother of my mother. And as any good mother, I am here to try to help my child.

She has had pneumonia twice. She has had an infection of the heart valve. She has a bacterial infection of the bloodstream. She has had two Hickman's catheters put into her. She has had shingles of the face due to the radiation treatment. She has had a drug-induced psychosis, infection of the middle ear drum, ulcerated foot. She has severe arthritis, emphysema, cancer of the larynx that is the doctor thinks spreading to the bone. And maybe after you hear my mother talk, I could elaborate more on it.

Senator BRADLEY. Yes, by all means. So let us run the videotape and then we will come back to you, Mrs. Roy.

[Videotape of inhome interview with Agnes Kelly shown.]

[Videotape interview with Mrs. Kelly, patient, by Ann Young.]

Ms. YOUNG. I am sitting here with Mrs. Kelly in her home and she is sitting in her bedroom with two of her favorite possessions. The first one is Barnibas, her cat, and the second one is the picture of Mrs. Kelly and Mr. Kelly on the occasion of their 25th wedding anniversary.

Tell us a little bit about this first, Mrs. Kelly. This is very precious to you.

Mrs. KELLY. Yes, he was very precious to me. He was one in a million, a wonderful man who never, probably never went out ever. [Blank in tape.]

This is my oldest, the one I live with here.

Ms. YOUNG. That's the daughter I met when I came in.

Tell me about this gentleman here.

Mrs. KELLY. He was my boyfriend since I moved here and I got the cancer and I took chemotherapy.

Ms. YOUNG. You had cancer. You had the chemotherapy.

Mrs. KELLY. A whole year of it.

Ms. YOUNG. One year.

Mrs. KELLY. Chemotherapy for a year. I believe two times everyday Monday through Friday. But it still kept growing.

Ms. YOUNG. The tumor still kept growing even though you had the chemotherapy.

Mrs. KELLY. I have it right in here. I have more every week. It's massive here.

Ms. YOUNG. Can you put your neck up and show me that mass.

Mrs. KELLY. I have it right here.

Ms. YOUNG. Uh-huh.

Mrs. KELLY. All the way over to here.

Ms. YOUNG. Yes.

Mrs. KELLY. There were two of them, both. Now, they seem to be growing together.

Ms. YOUNG. Going from here and going toward the middle.

Mrs. KELLY. Very tight. Very tight and very, very painful.

Ms. YOUNG. Now, you have this oxygen running here. Would you tell us how that helps you?

Mrs. KELLY. I have to have it. I can't breath without it. It's back there on the machine.

Ms. YOUNG. I see. It comes from the machine.

Mrs. KELLY. If the electric goes off, I have [blank in tape]. I have arthritis in my spine.

Ms. YOUNG. In your spine, arthritis.

Mrs. KELLY. I have emphysema of both lungs.

Ms. YOUNG. Emphysema in both lungs.

Mrs. KELLY. Yes. I really and truthfully [blank in tape].

Ms. YOUNG. I don't think you told me you have a hole right here in your neck and you close it off to talk. I don't think you told me what that was.

Mrs. KELLY. It's a trach.

Ms. YOUNG. Tracheotomy.

Mrs. KELLY. And 3 years ago [blank in tape]. I've been in the hospital too many times, and I don't want no more of going in the hospital. I'll just take my own bed.

Ms. YOUNG. In your own bed and in your own home.

Mrs. KELLY. Right.

Ms. YOUNG. Now, tell me. I know your daughter takes care of you. And who else takes care of you? Who else helps?

Mrs. KELLY. The home health aides comes Monday, Wednesday, and Friday from 1 to 4 o'clock.

Ms. YOUNG. 1 to 4 o'clock.

Mrs. KELLY. Right. She cleans around and just gives me my bath. She does all the things my daughter does Tuesday, Thursday, Saturday, and Sunday. Does the best she can. [Blank in tape.]

Ms. YOUNG. And I see that you have a urinary catheter in.

Mrs. KELLY. Yes, all the time. Has to be in. They take it out and I have a full bladder. It gives me too much pain, and it has to come out, and I have to call her to come out and put another one in.

Ms. YOUNG. Is that the professional nurse that comes and does that?

Mrs. KELLY. Yes.

Ms. YOUNG. And how often does she do that?

Mrs. KELLY. Well, I try to hold off as long as I can. Sometimes it gives me too much pain.

Ms. YOUNG. I see.

Mrs. KELLY. And I have to use the what-do-you-call-it to get rid of the pain, and the catheter comes out. Sometimes it falls out and it doesn't stay well. [Blank in tape.]

Ms. YOUNG. So you spend most of your days in this bed.

Mrs. KELLY. All the time.

Ms. YOUNG. A little bit on the chair?

Mrs. KELLY. All the time. Sometimes on the chair, but not often.

Ms. YOUNG. Then you just only use your commode and that's it.

Mrs. KELLY. Mostly in the daytime all the time. [Blank in tape.] I'd be lonesome without Eleanor. She's very good to me.

Ms. YOUNG. Who is Eleanor now?

Mrs. KELLY. She's a home health aide.

Ms. YOUNG. Eleanor is your home health aide?

Mrs. KELLY. Yes. Eleanor Segal. [Blank in tape.]

Ms. YOUNG. Thank you for your interview.

Mrs. KELLY. You are quite welcome I am sure.

Ms. YOUNG. Do you have questions to ask me?

Mrs. KELLY. Well, is there any reason why you had to have this? I mean, am I doing to still keep my health aid in my life?

Ms. YOUNG. As far as I know. The reason that I came here today to interview you is because Senator Bradley is going to have hearings in Newark, NJ, and he's going to be looking into the erosion of the Medicare home care benefit.

Mrs. KELLY. Right.

Ms. YOUNG. Because many people like you have an aide or a nurse or maybe a physical therapist or one of the other therapies or a social worker, and again and again, these services are being cut.

Mrs. KELLY. I hope they don't take them away.

Ms. YOUNG. I hope they don't take any more away either, but they have been taking them away.

Mrs. KELLY. I really need them. I really do.

Ms. YOUNG. I know you do. You need them for many reasons. I can see that. Our interview will be seen by Senator Bradley. You will tell him your story directly.

Mrs. KELLY. I hope he approves.

Ms. YOUNG. You hope he approves.

Mrs. KELLY. I hope he approves.

[End of interview with Mrs. Kelly.]

Mrs. ROY. Very quickly I would like to say that I think that with cancer people today, they are living longer. And they are needing help longer.

Again my mother was diagnosed of the cancer almost 4 years ago, and was given 4 months to live.

The nurses, what they did for me was astronomical. The first 18 months I stayed home with my mother. And toward the end of that 18 months, I was ready for the booby hatch. I was very concerned, crying, all the time depressed. I am not a young girl myself. I am going through a midlife crisis, or whatever you want to call it. And the nurses really persuaded me to go back to work. So, now, I do work, my mental health is much better. However, there is a lot of guilt of leaving my mother when she is this ill, not knowing what I am going to have when I come home.

Unfortunately, a doctor told her that there were three ways she would die. That she would choke to death, she would suffocate, or the tumor would hit a carotid artery and she would suffer a hemorrhage.

When I am not there, this is what she worries about. Will I find her in a mass of blood or something like that when I come home. This is the feeling I have when I leave my mother to go to work. There is a lot of guilt, should you work or should you not. I know that if I do not, it is going to be very bad.

The impact of my mother's illness on the family is just as profound. We cannot do anything as a family because someone wants to stay home with mommy. They do not want to leave her by herself. Again, this is the guilt that we put on ourselves, not that mom does.

The nurses, in the first 3 years mommy had the trach put in, were a super help. I am very squeamish, very squeamish. They showed me how to take the trach out, to sterilize it, to put it back; how to suction down into the trach into her lung, to get the mucous out. They showed me—she had two Hickman catheters put in. The nurses trained me to do this so that they did not have to come out unnecessarily, which helps. We are not using Medicare—the nurses taught me how to do all this. They came out once a week in the beginning.

She had the two Hickman catheters put in which goes into the heart valve. And they had to be flushed out with saline haprine, and they showed me how to make the solution up and how to take care of the catheter.

When she had the ulcerated foot, they told me how to bathe that, take care of that. The same with the incisions from the Hickman catheter.

When she had pneumonia when she came home from the hospital, because they send you home so soon, they showed me how to pound on her back to help move the mucous out of the lung.

They say that right now that she is in a condition where she is stable. However, 2 weeks ago, I came home and found her on the floor. She had passed out. She had otis median—I am not sure of the medical word—it is the middle ear drum that she had gotten a severe infection. Blood was coming out of the ear.

They, Medicare, have cut her back to once a month now. If the nurses would have been there, they would have realized that the itching that she was having in the ear, and maybe they could have prevented this problem.

Senator BRADLEY. What would you have done without any home health care nurses?

Mrs. ROY. Senator Bradley, I do not know what I would have done because I still spend many days crying. I am seeing my mother die, as this lady here, Mrs. Higham, or anyone else in here that has a loved one that is dying. She gave me everything.

I feel guilty when I have to leave her but, at the same time, I still have—I have kids, I have a grandchild, I have a husband. I have a life. And I am pulled between taking care that mommy has a good life, what is left of it, and being a wife and a mother and a grandmother.

I do think that if I was not working, and they, the nurses, made me go back to work, that I would be a mental case at this point. In fact, the emotional swing is back and forth. Some days you go 1, 2, or 3 days—and I think this lady, Mrs. Higham, will tell you the same thing—where you are crying and you are depressed. And we are in an age where depression comes kind of easy anyhow. And there are other times that you cope with it. There are times that you wish it were over, and then you hate yourself and you cry more. Because you are wishing your mother dead.

Without the nurses, I do not know what I would do. They are cut back to once a month now.

Senator BRADLEY. They are cut back to——

Mrs. ROY. Once a month.

Senator BRADLEY. The nurse comes once a month?

Mrs. ROY. Once a month. Once a month. Because she is stabilized at this point Medicare states.

Her tumor has grown 4 inches in the last 6 months. The nurses told me how to prepare mom's foods because, obviously, with a tumor of that size, she cannot swallow. And they make sure that I prepare a good diet. I make scrambled eggs with all kinds of cheese, grated cheeses, and all kinds of rich things. I make a pie that is delicious but it will put 20 pounds on you. You know, just to keep her strength up.

The nurses keep me informed. And my mother—when they said that there would only be a nurse once a month, mommy got very ill and decided she was going to die, and stayed in bed. And I do not know if it was psychological or not, but the pain was very bad, and the doctor put her on more morphine, you know, she is allowed to take it every 4 hours.

The doctor had said to me that he wanted the nurse coming every week, because he was thinking about using some kind of an intravenous type morphine for her.

Senator BRADLEY. You said the doctor wanted a nurse every week?

Mrs. ROY. He would. But the thing is that Medicare will not pay for it. My mother gets only—I will be very honest—my mother gets Social Security, about $400 a month. That is it. My father worked very hard all of his life in a factory. They were poor Irish, not much education, but they worked hard. Good people.

And I think that the dignity of dying should be there. I do not think that they should just die like a pauper. She does not want to go into—I would not put her in a nursing home. There would be no way that I would have to—there is just no way. My mother should be with me. And she wants to die at home.

The nurses give her a feeling of comfort. And me, the security—I mean 4 o'clock in the morning, when you have been up 5 hours and she is crying in pain. They are the ones I can call on. After mom has had a couple of doses of morphine in her, and is relatively out of pain. Well, if Medicare could see how she gets because it hurts her.

Senator BRADLEY. The nurses help you keep your family together?

Mrs. ROY. Oh, my God, yes. Yes.

In the beginning, I missed my daughter being in a school play. I would not leave my mother. I tell you no lie—may God strike me—I did not leave my mother to hang wash out because I was afraid, like the doctor said, she was going to suffocate, choke to death, or hemorrhage. Not that I could help it if the time came. I could just stand there. But it would be comfort for mommy knowing that I was there.

So, the first 18 months were really wicked. And the one health nurse, Sue Childs, she was the one who, she said, Patsy, you have to go to work or you are just going to be as sick as your mother. And, of course, I think this is true since I have been working this last year. I help mom better. But that is my problem. (Going back to the beginning, the guilt of not being here, et cetera, versus working and occupying my mind with things other than momma's illness.)

Senator BRADLEY. Well, I think you made a—I would say an extremely moving presentation—not only about the need for home health care, but also moving testimony of the love of a daughter for her mother. And I would say the same to you, Mrs. Higham for a willingness to come in a public setting and share your very personal stories. And I think that your testimony will help, and I intend to see that it will help. And I would also like to thank Mrs. Trimble who gave us a very concise and clear explanation of the value

of these services to her, and to Ms. Edelson as well for allowing us to bring all of you and share your feelings with us.

Mrs. Roy. Thank you. Thank you, Senator. [Applause.]

Senator BRADLEY. Now, our next panel will be a panel of providers of health care: John Paul Marosy of the Home Health Agency Assembly of New Jersey; Jim Schuessler, Community Memorial Hospital, Toms River; Elana Zucker, Overlook Hospital, Summit; Maralyn Zuchowski, Visiting Nurses Association, Somerset Valley; and Lois Hull, Essex County Office on Aging.

I would like to welcome you all to the panel. And I would like you, if you could, due to our time constraints, if you could keep your testimony to 5 minutes so that we could get to some questions, I think that that would be extremely helpful.

Let us begin with Mr. Marosy. Welcome to all of you, and we hope to benefit a good deal from your testimony because you are on the provider end of this equation, and we have just heard, as I said, a very moving set of personal histories from the recipients of home care. I look forward to your testimony.

STATEMENT OF JOHN PAUL MAROSY, EXECUTIVE DIRECTOR, HOME HEALTH AGENCY ASSEMBLY OF NEW JERSEY, INC.

Mr. MAROSY. Thank you, Senator, and good morning.

The patients and families who we have just heard have told the story of cutbacks in Medicare home health care services in clear and graphic terms. The experienced nurses who accompany me on this panel will explain how and why care was denied for these specific people. Our survey data shows that their stories are not isolated incidents but, rather, they represent the tip of the iceberg.

We are proud of the high quality of care in home health care that is provided for New Jerseyans. Last year, the 55 certified home health agencies served 132,000 New Jerseyans of all ages.[1] They provided these services in cooperation with proprietary and not-for-profit homemaker/home health aide providers and with the county offices on aging.

Senator, there is a quiet crisis brewing behind the closed doors of thousands of older and disabled Americans. The policies of the Federal Health Care Financing Administration, under the strong influence of the Federal Office of Management and Budget, are pushing an increasing number of sick, old, and disabled people into a "no care zone." The Federal Government is no longer willing to pay for recuperative care in the hospital. This means that patients are coming home earlier and need to recuperate at home. The good news is that home health agencies have geared up with more high technology services, more evening coverage, more weekend coverage. The bad news is that at the very time when these patients need more intensive home health care help, the Medicare Program is restricting access to home care services by tightening eligibility guidelines, leaving many people with no care.

An increasing number of claims are being denied. In addition, home health agencies are being strangled in redtape which is having a devastating impact on the morale of the nurses, social

[1] See appendix, item 1.

workers, therapists, and home health aides who provide these vital services to people in need.

To understand what is happening, I would like to draw on an analogy. Let us think of the Medicare statutory entitlement as a box.

The left side of the home care box is the requirement that a Medicare patient qualify for skilled nursing care. In other words, a patient must be sick enough to need intensive and medical care, as distinguished from personal care alone.

The right side of the box is defined by the term "intermittent care." In other words, the patient must not be too sick. He or she must need care intermittently as opposed to a full-time basis. As far as Medicare is concerned, patients who need care more frequently than on an intermittent basis are too sick to be cared for at home, and should be in a nursing home. This makes no sense as a matter of public policy, but such is the rule.

The bottom of the box is the term "homebound." According to regulations, this means that an individual qualifies for care if he or she needs the assistance of a walker or wheelchair, or another person to leave home. In practice, this requirement is being defined more and more restrictively to the point where it has come to mean "bedbound."

The top, or the lid, of the box relates to the fact that care must be ordered by a physician and must be, in the judgment of Medicare officials, reasonable and necessary toward improving the patient's condition.

Over the last 2 years, the Health Care Financing Administration has added layer after layer of redtape, restricting the benefit, and bringing each of the four sides of the box closer and closer together. At the same time, the number of patients being discharged to home care from hospitals has increased some 37 percent nationwide. As a result, thousands of people are being squeezed out of the home care box and into the "no care zone." In New Jersey the problem is huge.

We conducted two surveys of home health agencies over the past 18 months, and we have reviewed data collected by the New Jersey Health Department and the Home Care Council of New Jersey. Here are the facts:

The number of Medicare claims denials increased by 27 percent between 1983 and 1984.[2] Denials increased by an additional 65 percent between 1984 and 1985.[3]

About 1,800 persons were affected by these denials in 1985, compared to about 1,100 persons the year before.

Senator BRADLEY. Would you repeat those numbers, please?

Mr. MAROSY. About 1,800 persons were affected by these denials in 1985, compared to about 1,100 the year before.

In 1985, the most frequently denied services were: First skilled nursing; second, physical therapy; third, home health aid; fourth, medical social work; and, fifth, occupational therapy.

In 1984, additional paperwork and documentation requirements added an average of $27,000 per agency in administrative overhead

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[2] See appendix, item 1.
[3] See appendix, item 1.

costs. That means buying copying machines and paying clerks to do paperwork.

Agency directors report that the definition of the number of usual and acceptable number of hours of homemaker/home health aid services per week has been reduced from 20 hours per week 3 years ago, to 9 hours per week last year, to 6 hours per week at this time.

Senator BRADLEY. Go over those numbers again.

Mr. MAROSY. Three years ago, the average and usual amount of home health aide services was 20 hours a week.

Senator BRADLEY. The average home health services actually provided by home health agencies?

Mr. MAROSY. When they screen the claims, Senator, they look at how many hours you are asking to provide the patient. Three years ago, if it was 20 hours or less, they routinely approved it. Then it was dropped to 9 hours, and now it is at 6 hours per week.

Senator BRADLEY. In other words, you do not get reimbursement over 6 hours a week?

Mr. MAROSY. Only if you can provide extraordinary documentation for services above that level. Then you can receive more than 6 hours a week.

Forty-six percent of the patients served by the States nonprofit homemaker/home health aid providers now receive 6 hours or less per week, averaging less than 1 hour per day.

Eighty-eight percent of the States home health——

Senator BRADLEY. Three years ago, it was 20 hours per week. In other words, an individual who could be in some of the categories that we have heard today, these personal stories, 3 years ago could get 20 hours of home health care services, and today can only get 6?

Mr. MAROSY. On the average, that is true.

Eigthy-eight percent of the States home health administrators responding to our most recent survey agreed with the following statement: "Over the past year, Medicare home health care claims denials have become so restrictive as to compromise the quality of care available to Medicare beneficiaries."

Eighty-eight percent of the experienced home health care nurses, some of them in the business for 15 years, feel that Medicare's policies are compromising the quality of care.

These cutbacks have taken place behind the scenes, outside the glare of public scrutiny. Substantive changes, which should be published for comment in the Federal Register before implementation, have informally been implemented through guidelines published in HCFA manuals or through written or verbal policy directives. HCFA requires that the fiscal intermediaries who process the claims find at least $5 in disallowed claims for every $1 the fiscal intermediary spends in an auditor's salary. Intermediaries who fail to meet this guideline are in danger of losing their contract with the government.

Senator BRADLEY. They require you to find $5 of what?

Mr. MAROSY. The Federal Government requires the fiscal intermediary to find 5 dollars' worth of claims denied for every $1 they spend on an auditor's salary.

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Senator BRADLEY. So that you have an auditor within your own agency.

Mr. MAROSY. No. These are auditors sent by the fiscal intermediary, which is an insurance company that has a contract.

Senator BRADLEY. So if Prudential sends its auditor to a home health care agency and that auditor gets $20,000 in salary a year. That auditor has to find $100,000 in ineligible payments to beneficiaries?

Mr. MAROSY. That is the guideline.

Senator BRADLEY. Well, I have heard of the policemen in the southern towns that waits on the outskirts for an out of State license plate so they can pull them in. [Laughter and applause.]

Mr. MAROSY. In summary, Senator, unless Congress intervenes, HCFA will have effectively dismantled the home health benefit. In order to protect the benefits Congress intended for Medicare beneficiaries, we recommend the following six action:

First, Congress should amend the provision in the Medicare law which limits those receiving home care to those needing intermittent care. It is a cruel hoax to tell the elderly that they cannot be cared for because they need too much care, or they are too sick and, therefore, belong in a nursing home. Medicare pays for a very limited amount of such nursing home care.

Second, Congress should block the Health and Human Service Department from denying Medicare home health care benefits to individuals who supplement the care provided by Medicare. If families want to pay privately for additional coverage, they should be able to do so without causing a loss of Medicare's benefits.

Third, Congress should enact legislation which clarifies the right of providers to assist Medicare beneficiaries in appealing their claims that have been denied by Medicare.

Fourth, Congress should consider exempting home health agencies from the Gramm-Rudman cuts and/or enacting a technical amendment which would make reductions in a more equitable manner, one which takes into consideration the unfair effect of including within across-the-board reductions applicable to block grants reductions in cost-based reimbursements. It is a different method by which home health care is reimbursed.

Fifth, Congress should immediately enact provisions agreed upon in 1985 by the House Ways and Means Committee and the Senate Finance Committee which released agencies from the July 1, 1985, regulations changing the formula for computing cost limits applicable to the agencies.

And sixth, and finally, Congress is urged to enact legislation requiring the Department of Health and Human Services to comply with the Federal Administrative Procedures Act. There is strong evidence on the record that HSS has acted arbitrarily, that it has reduced the value of the Medicare entitlement, and that it has crossed the line between policymaking, which is the prerogative of the Congress, and policy implementation.

Thank you for the opportunity to present our concerns.

Senator BRADLEY. Thank you very much, Mr. Marosy, for a very informative speech. [Applause.]

What did you say about intermittent care in your first point?

Mr. MAROSY. My first point on intermittent care is simply that this tightening of the benefits should be removed completely from the law.

Senator BRADLEY. You would eliminate the requirement that it be intermittent?

Mr. MAROSY. I think that it could be entirely eliminated, Senator, or clarified in a way that would not leave as much discretion for the fiscal intermediary.

There is a bill that has been introduced, H.R. 2371, which would clarify that the term "intermittent" would not block the care of individuals who would otherwise qualify for daily visits up to 90 days.

Senator BRADLEY. I am a cosponsor of that bill. Thank you.

Mr. MAROSY. Senator, I think we have one other tape of a family in Gloucester County which is ready to roll if you would like to see it.

Senator BRADLEY. Fine. Let us run the tape.

[Videotape shown.]

[Videotape interview with Mrs. Guy Robinson by Ann Young.]

Mrs. ROBINSON. And I wouldn't put my husband, John 6 and 12, says when I was hungry, when I was a stranger, he took me not in; and when I was hungry, he fed me not; when I was naked, he clothed me not; and when I was sick, he visited me not. Depart from me that was iniquity. So that God means for us to visit the sick and take care of the sick. He don't mean for us to throw them away.

So that's what goes on. And he said, when he married us, he said do you take this man to be your wedded husband, to live together after God's own sake of the heart, will you love him, care for him through sickness, death and health until we part? So that's what we're going to do.

Ms. YOUNG. That's what you've had to do?

Mrs. ROBINSON. That's right.

Ms. YOUNG. And what are you about to do now?

Mrs. ROBINSON. Give him this antibiotic.

Ms. YOUNG. How many other medicines do you have to give him too?

Mrs. ROBINSON. Well——

Ms. YOUNG. I count about six. Is that about right?

Mrs. ROBINSON. That's right. You got it.

Ms. YOUNG. How do you do it? Do you crush them up?

Mrs. ROBINSON. Yeah, uh-huh. I take the stem and beat them up——

Ms. YOUNG. Explain that to us. What are you doing with that now?

Mrs. ROBINSON. This is his feeding tube.

Ms. YOUNG. And that's his feeding tube?

Mrs. ROBINSON. It goes in his nose. And that's so he can eat. See, when it hits his nose, you cut it back to 75.

Ms. YOUNG. What's that 75 for?

Mrs. ROBINSON. That's how many drops. He gets an ounce.

Well, Mr. Robinson has four strokes. He worked——

Ms. YOUNG. Four strokes?

Mrs. ROBINSON. He had two, his brain, 18 percent of his brain is damaged. He don't know 1 day from the other.

Ms. YOUNG. Uh-huh.

Mrs. ROBINSON. And he don't nothing about what you hand to him now.

And also he cannot use either one of his hands. See, this hand is stiff like that in the hospital.

Ms. YOUNG. How long has Mr. Robinson been that way?

Mrs. ROBINSON. He's been there 5 years.

Ms. YOUNG. He's been like this for 5 years?

Mrs. ROBINSON. Five years.

Ms. YOUNG. And you've been doing his nursing care those years?

Mrs. ROBINSON. That's right. That's right.

And turned him over.

Ms. YOUNG. Mr. Robinson is 86 years old?

Mrs. ROBINSON. Yes.

Ms. YOUNG. And you are, may I ask?

Mrs. ROBINSON. Seventy-six.

Ms. YOUNG. You are 76 years old?

Mrs. ROBINSON. That's right.

Ms. YOUNG. And how is your health?

Mrs. ROBINSON. Not worth a dime, but I keep going.

Ms. YOUNG. Not worth a dime.

Tell me about your health.

Mrs. ROBINSON. Well, you see, I have a pacemaker first thing.

Ms. YOUNG. When did you get your pacemaker?

Mrs. ROBINSON. I have had it about 10 years.

Ms. YOUNG. Ten years.

Mrs. ROBINSON. The lasting one. I take three and they did fail on me.

Ms. YOUNG. What did the doctor say about your legs?

Mrs. ROBINSON. He tell me to stay off them. How can you stay off them when there's somebody in the house sick? That's dumb.

Ms. YOUNG. Are they very swollen? They look swollen to me.

Mrs. ROBINSON. They is swollen.

Ms. YOUNG. Uh-huh.

Could I see just one?

Mrs. ROBINSON. Yeah, you can see them. You can see both of them.

Ms. YOUNG. Um.

Mrs. ROBINSON. This one is worse than the other. And I don't rest with them at night cause they hurt. See that?

Ms. YOUNG. What help do you have?

Mrs. ROBINSON. I have a girl come in at 9, and she's—that's 8 hours.

Ms. YOUNG. Uh-huh.

Mrs. ROBINSON. And for him.

Mrs. YOUNG. For him?

Mrs. ROBINSON. Yeah.

And bathe him, change his room. That's it.

Ms. YOUNG. Didn't you use to have the home health aide more often than that?

Mrs. ROBINSON. When I first started, 7 days a week. They cut it back.

Ms. YOUNG. Medicare cut the aide back?

Mrs. ROBINSON. Whoever runs the business, yes, whoever is doing the business in Medicaid cut it back.

Ms. YOUNG. You told me earlier that your husband built this house.

Mrs. ROBINSON. Yes, he did.

Ms. YOUNG. And that's one of the reasons you're so attached to it?

Mrs. ROBINSON. Yes. And not only that, I love my husband. If I didn't, I wouldn't have married him.

Ms. YOUNG. No.

Mrs. ROBINSON. I didn't marry him for a home because I had a home.

Ms. YOUNG. Uh-huh.

Mrs. ROBINSON. I married him because I loved him.

Ms. YOUNG. And you're keeping your husband home here in this house because you think this is what he likes?

Mrs. ROBINSON. It's better than being in a nursing home.

[End of interview with Mrs. Robinson.]

Mr. MAROSY. Senator, this family in Glouster County, their home health aid services were cut back from 7 days a week to twice a week, 3 hours per day.

Senator BRADLEY. I want to thank you, Mr. Marosy, not only for your testimony, but also for the tape which once again makes us all realize that we are not dealing with numbers, we are dealing with people.

Mr. MAROSY. Thank you, Senator.

[The prepared statement of Mr. Marosy follows:]

Prepared Statement of John Paul Marosy

Good morning, Senator. I am John Paul Marosy, Executive Director of the Home Health Agency Assembly of New Jersey. The patients and families who we have just heard have told the story of cutbacks in Medicare home health care services in clear and graphic terms. Our survey data shows that their stories are not isolated incidents, but rather, they represent the tip of the iceberg.

We are proud of the high quality of care that home health agencies provide for New Jerseyans. Last year the 55 certified home health agencies served over 132,000 New Jerseyans of all ages. They provided these services in cooperation with proprietary and not-for-profit homemaker/home health aide providers and with the county Offices on Aging.

Senator, there is a quiet crisis brewing behind the closed doors of thousands of homes of older and disabled Americans. The policies of the federal Health Care Financing Administration (HCFA), under the strong influence of the federal Office of Management and Budget (OMB), are pushing an increasing number of sick, old, and disabled people into a "No Care Zone." The federal government is no longer willing to pay for recuperative care in the hospital. This means that patients are coming home earlier and need to recuperate at home. The "good news" is that home health agencies have geared up, with more high technology services, and with more evening and weekend coverage, to meet the more intense needs of people discharged earlier from the hospital. The "bad news" is that at the very time when these patients need more intensive home health care help, the Medicare program is restricting access to home care services by tightening eligibility guidelines - leaving many people with no care. An increasing number of claims are being denied. In addition, home health agencies are being strangled in red tape which is

having a devastating impact on the morale of the nurses, social workers, therapists and home health aides who provide these vital services to people in need.

To understand what is happening, I would like to draw on an analogy first presented by my colleague, Val Halamandaris, President of the National Association for Home Care. Let's think of the Medicare statutory entitlement as a box.

The left side of the home care box is the requirement that a Medicare patient qualify for skilled nursing care. In other words, a patient must be sick enough to need intensive and medical care, as distiquished from personal care alone. One element of skilled care, for example, is that a patient must have rehabilitative potential. This is the fundamental threshold which all patients must cross in order to be covered.

The right side of the box is defined by the term "intermittent care." In other words, the patient must not be too sick. He or she must need care intermittently, as opposed to a full time basis. As far as Medicare is concerned, patients who need care more frequently than on an intermittent basis are too sick to be cared for at home, and should be in a nursing home. This makes no sense as a matter of public policy, but such is the rule.

The bottom of the box is the term "homebound." According to regulations, this means that an individual qualifies for care if he or she needs the assistance of a walker, or wheelchair, or the aid of another person to leave home. In practice, this requirement is being defined more and more restrictively to the point where it has come to mean "bedbound."

The top, or the lid, of the box relates to the fact that care must be ordered by a physician, and must be, in the judgement of Medicare officials,

"reasonable and necessary" towards improving the patient's condition.

There were other limitations in the statute which were removed by Congress in 1980. For example, prior to that time, for-profit agencies were not allowed to participate. Second, there was a limit of 100 visits in any particular year. Third, in order to qualify for benefits, a person had to first be hospitalized for three days.

In place of these limitations, HCFA has, over the last two years, added layer after layer of red tape, restricting the benefit, and bringing each of the four sides of the home care box closer and closer together. At the same time, the number of patients being discharged to home care from hospitals has increased some 37%, nationwide. As a result, thousands of people are being squeezed out of the home care box and into the No Care Zone, according to a survey conducted by the National Association for Home Care.

In New Jersey, the problem is huge. We conducted two surveys of home health agencies over the past 18 months, and we have reviewed data collected by the New Jersey Health Department and the Home Care Council of New Jersey. Here are the facts:

*The number of Medicare claims denials increased by 27% between 1983 and 1984. Denials increased by an additional 65% between 1984 and 1985.

*About 1,815 persons were affected by these denials in 1985, compared to about 1,100 persons the year before.

*In 1985, the most frequently denied services were 1.Skilled Nursing, 2.Physical Therapy, 3.Home Health Aide services, 4.Medical Social Work, 5.Occupational Therapy.

*In 1984, additional paperwork and documentation requirements added an average of $27,000 per agency in administrative overhead costs.

*Agency directors report that the definition of the number of "usual and acceptable" number of hours of homemaker/home health aide services per week has been reduced from 20 hours per week three years ago to 9 hours per week last year, to 6 hours per week, at this time. 46% of the patients served by the state's non-profit homemaker/home health aide providers now receive six hours or less per week - averaging less than one hour per day.

*88% of the state's home health administrators responding to our most recent survey agreed with the statement that "Over the past year, Medicare home health care claims denials have become so restrictive as to compromise the quality of care available to Medicare beneficiaries."

These cutbacks have taken place "behind the scenes," outside the glare of public scrutiny. Substantive changes, which should be published for comment in the Federal Register before implementation, have informally been implemented through guidelines published in HCFA manuals or be written or verbal "policy directives." HCFA requires that the Fiscal Intermediaries, who process the claims, find at least $5.00 in disallowed claims for every $1.00 the Fiscal Intermediary spends in an auditor's salary. Intermediaries who fail to meet this standard are in danger of losing their contract with the government.

The effect of these measures has been devastating. Unless Congress intervenes, HCFA will have effectively dismantled the home health benefit. In order to protect the benefits Congress intended for Medicare beneficiaries to receive, we recommend the following the following six actions:

1. Congress should amend the provision in the Medicare law which limits those receiving home care to those needing "intermittent care." It is a cruel hoax to tell the elderly that they cannot be cared for because they need too much care and are too sick, and therefore, belong in a nursing home. Medicare

pays for a very limited amount of such nursing home care. Only about 7,000 of the 1.3 million patients in nursing homes on any given day have their care paid for by Medicare, and their reimbursed stays tend to be very short--an average of 25 to 30 days. If the Congress insists on limiting the home care benefit, there are better ways to do so. HR 2371 would make it clear that the term "intermittent" would not block the care of individuals who other wise qualify for daily visits up to 90 days.

2. Congress should block HHS from denying Medicare home health benefits to individuals who supplement the care provided by Medicare. If families want to pay privately for additional care needed by relatives, they should be able to do so without causing a loss of Medicare's benefits.
3. Congress should enact legislation which clarifies the right of providers to assist Medicare beneficiaries in appealing claims that have been denied by Medicare.

4. Congress should consider exempting home health agencies (HHAs) from the Gramm-Rudman cuts and/or enacting a technical amendment which would make reductions in a more equitable manner, one which takes into consideration the unfair effect of including within across-the-board reductions applicable to block grants reductions in cost-based reimbursements.

5. Congress should immediately enact provisions agreed upon in 1985 by the House Ways and Means Committee and the Senate Finance Committee which released agencies from the July 1, 1985 HHS regulations changing the formula for computing cost limits applicable to agencies.

   The new rules barred agencies who were efficient from using savings in one area of service (e.g., nursing) to provide service in another area (e.g., physical therapy). This principle is called aggregation. The proposal as passed by the Senate would allow agencies to aggregate costs, at the same time preserving reductions in overall cost caps applicable to those agencies which had been mandated by HHS.

6. Congress is urged to enact legislation requiring the Department of Health and Human Services (HHS) to comply with the Federal Administrative Procedure Act. There is strong evidence on the record that HHS has acted arbitrarily, that it has reduced the value of the Medicare entitlement, and that it has crossed the line between policy making, which is the prerogative of the Congress, and policy implementation.

Thank you for the opportunity to present our concerns.

Senator BRADLEY. Let us go on with Mr. Jim Schuessler of the Community Memorial Hospital. Mr. Schuessler.

STATEMENT OF JAMES SCHUESSLER, TOMS RIVER, NJ, PRESIDENT AND CHIEF EXECUTIVE OFFICER, COMMUNITY MEMORIAL HOSPITAL HEALTH SERVICES CORP.

Mr. SCHUESSLER. Good morning, Senator.

My name is Jim Schuessler, and I am the president and chief executive officer of Community Memorial Health Services Corp. in Toms River, NJ. The organization I represent consists of a parent holding corporation, a not-for-profit hospital operating corporation, a public foundation, and Center State Health Group—a diversified, not-for-profit corporation, whose holdings include the 225-bed Country Manor Nursing Home.

Community Memorial Hospital, the flagship of our family of organizations, is a 460-bed regional health care center in Toms River. Importantly, 65 to 70 percent of the patient days that we provide each year are delivered to Medicare beneficiaries. Perhaps more importantly, 40 percent of our patient days are provided to persons over the age of 75. Among our many programs having a direct focus on the elderly and their special health care needs is a hospital-based Medicare certified home care department.

I am appreciative of the opportunity to present the position of our hospital on some of the topics of current interest, and I congratulate you for your honest and sincere inquiry into the issues facing our country in dealing with the growing health care delivery problems of an increasingly aged population. In many ways, the population of our hospital's service area in Ocean County, and that population's impact on the health delivery system, foretells what the rest of our country will be like in the future, as citizens live longer, and as those older Americans become a larger and larger percentage of our population. Located in the heart of some 13 major retirement complexes, the age mix of our patient group has given our local health care system considerable experience with and empathy for the needs of the frail elderly.

Life for all health care providers has changed dramatically in recent years, perhaps in no location so much as in New Jersey. State and Federal regulations have focused on the high cost of delivering high quality health care and on mechanisms designed to reduce increases in those costs. All of us, as citizens and taxpayers, have a stake in the success of these many initiatives. But, likewise, all of us as potential and in fact inevitable patients, have an equal stake in ensuring that the necessary initiatives to contain costs do not compromise quality of care or the dignity and independence of the ill and the elderly.

I suspect that you appreciate that my hospital does not operate under the Federal PPS system, by which Medicare reimburses most hospitals in this country for the care of Medicare beneficiaries. The State of New Jersey has been granted a waiver to operate its own DRG based reimbursement system. DRG, of course, stands for "De Revenue is Gone." [Laughter.]

This all-payor system began some years ago as an early model of the yet to be developed Federal system, which has now been man-

dated by Congress. According to information supplied by the New Jersey State Department of Health in its application to the Government for the waiver, the New Jersey system will result in Community Memorial Hospital receiving nearly $10 million less in Medicare dollars during the period 1985 to 1987 than it would have received under the Federal system. The millions of dollars which the Congress, in designing the PPS system, intended to be allocated for the care of Medicare patients in this one hospital, are being consumed by a complex State reimbursement system that is baffling even to some of its own architects. As the waiver nears collapse, I am concerned that yet another scheme to fund medical education and indigent care with Medicare dollars will succeed the current system.

Notwithstanding our problems with the Medicare waiver, our hospital shares many experiences with hospitals around our State and around our country relative to the elderly and various cost containment initiatives.

Patients discharged from hospitals today have greater need for postacute care than ever before.

Readmission rates are increasing.

Patients are discharged earlier in the course of their recovery.

Medicine is providing survival for disease and accident victims who in earlier years did not survive. Therefore, the numbers of disabled and chronically ill persons are on the rise. I think our review of the videos this morning amply demonstrates that.

The average length of stay for patients in home care programs is increasing as these programs care for ever more acutely ill patients.

And physicians feel inappropriately pressured by the PRO system to hurry patients out of the hospital.

Our hospital and our medical-dental staff members are gravely concerned with maintaining the continuity of high quality care for patients following discharge. The fiscal intermediary for our home care program, the Prudential Insurance Co., has recently given many indications of interpretations of existing Medicare entitlements that will severely compromise that continuity of care.

Specifically, denial rates for Medicare home care claims have tripled in the first quarter of 1986 compared to the same period in 1985. And that tripling is for a home care population, 52 percent of whom are over the age of 75.

To give you an example of the types of denials that we are receiving, I will give you a couple of anecdotal incidents:

One is a patient with a neuromuscular/skeletal diagnosis that includes a fractured hip, fractured leg, and a fractured ankle which required a full cast of one side of the patient's body.

The intermediary denied home physical therapy services altogether with the stated reason being that the patient should have received therapy instructions prior to discharge.

Patients with chronic levels of illness. For instance, a patient with congestive heart failure and arteriosclerotic heart disease whose symptoms escalated at the end of the 3-week period for which home care visits were approved, ran into difficulty. The patient's condition absolutely required an additional visit to assess in-

creased swelling and to reinforce medication compliance. This visit was denied coverage as well.

Generally, it has been nearly impossible to obtain approval for medical social work visits. We have not had a single such visit approved for reimbursement in the last 6 months. These visits are essential in keeping the frail elderly in a home setting. The alternative to the self-confidence and stress reduction that these visits provide is all too often institutionalization.

When institutionalization is the best alternative, there are many quality nursing homes in Ocean County, including our Country Manor. And more are needed. Country Manor is unique with its Coma Program, however, wherein comprehensive care is provided to long-term coma patients.

There is a need for adult medical day care and residential health care programs and facilities in Ocean County.

The following recommendations are made by our hospital to support containment of health care costs and to promote high quality dignified care. I commend them to your most serious consideration, and I will try to run through them very quickly.

One is to mandate increased coverage of home care in major medical plans.

Two, require increased emphasis on home health care coverage and other cost-saving treatment modalities in employer-supplied health insurance programs.

Three, create significant tax incentives to encourage families to care for the long-term needs of chronically ill family members at home, a change that will in itself generate huge savings to the system.

Establish tax exemption of IRA funds used to finance long-term care.

Encourage programs which permit older Americans to utilize equity in their homes to finance home care without necessitating selling those homes during their lifetime.

Develop a prospective payment system for Medicare certified home care.

Mandate a full and comprehensive home care program as a dramatic cost control mechanism for the Veterans' Administration system.

Support the extension and expansion of the program which provides hospice benefits under Medicare, allowing terminally ill beneficiaries to be cared for and, if they choose to do so, to die in their home.

Critically evaluate the PRO Program, most especially in terms of reestablishing review of care on an ongoing concurrent basis rather than retrospective analysis based on medical records long after the care has been rendered.

I thank you on behalf of our patients for your interest and concern for their future. And I invite you to visit our hospital, our home care program, our nursing home, and our other facilities to see for yourself the successful effort of over 2,300 employees who are dedicated to that future.

Senator BRADLEY. Thank you very much, Mr. Schuessler, for your testimony.

In the previous testimony of Mr. Marosy, he mentioned the dramatic increase in the number of denials for Medicare coverage in even the limited categories that are set by the Federal guidelines.

My question to you is this: Have you seen an increase in readmissions to hospitals that tracks this increase in denials?

Mr. SCHUESSLER. Yes.

It is difficult, as I am sure you can appreciate, to determine cause and effect in a situation as complex as the hospital and home care of very elderly persons.

But our hospital has seen a very dramatic increase in the readmission rates of patients that are discharged to home care.

It is our experience that many of those readmissions are a result both of the patient being pressured to leave the hospital by the PRO system, and perhaps more importantly by the inability of the home care program to render the level of service that they would like to provide to that patient in the home to keep them out of the hospital.

It is perhaps the best example that I can think of of a policy of Government that makes sense, both from a financial and from a humanistic point of view.

Senator BRADLEY. Let us take the social work services that are being denied. Do you feel that when they are provided, people can be kept in their homes in the long term at less cost to the taxpayer than what it costs to put them back in the institutions, in the hospitals?

Mr. SCHUESSLER. I think that that is an absolutely correct conclusion. And in fact it seems to have been borne out by some of the testimony earlier this morning.

I think that we all heard a moving example of the desire of families to meet their commitment to their ill family members but are unable to do so because they cannot get the support from the system that they deserve.

We have the resources. In many cases, we expend those resources, and our program is losing money because we continue to provide services that we know the patients need but which medicare is unwilling to provide reimbursement for. We can do that for a short period of time. In the long run, the patients are going to become the victims of the system not functioning properly.

Senator BRADLEY. Thank you very much for your testimony.

And now let us hear from Elana Zucker of Overlook Hospital in Summit, NJ.

Welcome to the Aging Committee, and you may begin.

STATEMENT OF ELANA ZUCKER, SUMMIT, NJ, DIRECTOR OF COMMUNITY HEALTH SERVICES, OVERLOOK HOSPITAL

Ms. ZUCKER. Thank you.

I am Elana Zucker, the director of community health services at Overlook Hospital. And I wish to discuss the denial of home care services by Medicare on their grounds of not reasonable and not homebound.

First, the people who decide these denials are not health care professionals. They have never cared for a patient. They are not familiar with diagnosis, or usual standards of care, and the implica-

tions for their denials, as they pertain to the individuals and his total health and well-being. These people who dictate the denials work in a vacuum without total assessment or understanding of the public's need.

Second, the precise guidelines and/or the standards that are employed by Medicare in deciding which services will be denied are unavailable to the industry. Broad guidelines are shared, but changes are not, and neither are the exact documentation requirements or the wording which is used to indicate one level of care or another. Additionally, when interpretive changes occur, these changes are not readily disseminated to the industry.

Third, the industry has attempted to raise standards of care and its capabilities to safely care for very sick patients at home. The Medicare system, by its capricious alteration of interpretation and direction, however, seems to be running counter to this raising of standards. Medicare seems, by its decrease in reimbursement, to be pressing the industry to deliver less care at a lower level and by lower paid staff. At a time when the elderly population is growing, the hospital readmissions from home care are growing and patients at home are sicker. This decrease in care seems to fly in the face of reality, and the stated intent of Medicare to curtail hospital stays and assist the elderly in their homes.

The denial of Mrs. Trimble, which was the patient you saw before, on the grounds of not reasonable and not homebound exemplifies the catch-22 that both the elderly patient and the home health community find themselves. On the one hand, Mrs. Trimble must leave the hospital, inconvenience her family, and accept the help of a local home health agency. And because she tries too hard, gets therapy, learns to be somewhat independent with help, and was able to walk 5 feet with assistance, she was judged not homebound. Certainly walking 5 feet with help does not allow a person to leave the house on a regular basis.

In this situation, the client is confused and angry that Medicare has not supported her in her attempt to recover from her hospital stay and has not provided her with the care for a reasonable period of time, for her, not for someone else.

The home health agency is angered and confused because it is not being permitted to complete the care of this patient as it was planned according to doctor's orders. Therefore, the next time a similar patient presents itself, the agency will hesitate to accept the case fearing another denial and another infringement on care.

It is wrong to have professional care dictated by nonhealth care people far away who only demonstrate their concern for the financial bottom line and not how that bottom line impacts upon individuals.

The Government states it fosters home care. That is not so. What it seems to foster is that patients remain and/or return home. The fostering of care often is another matter and not always evident at all.

Thank you.

Senator BRADLEY. Thank you very much, Ms. Zucker, for your testimony.

Should I take from your testimony that you believe that there should not be a homebound requirement in the law?

Ms. ZUCKER. That is loaded.

I think that there should be requirements in all laws. But I think that the interpretations of those requirements should be obvious and should be shared with everybody so both the public and the industry have the same guidelines to work with. And at this point, that is not so.

Senator BRADLEY. How important is discharge planning in assuring that there will be resources in the community available for the person who is being discharged from the hospital?

Ms. ZUCKER. Discharge planning is a wonderful service. And a discharge plan that Overlook Hospital report to me so I really do know what they do.

Their responsibility is the discharge of patients from the hospital. But they are not involved at all with the interpretations of those rules once the patient leaves the hospital. So I think that the two things have to work together but I am not sure that the discharge planning in this particular instance would assist the patients at home all the time.

Senator BRADLEY. When there is very good discharge planning coupled with some resources for home care, then you believe the two work very well together.

Ms. ZUCKER. Yes, sir.

Senator BRADLEY. Is discharge planning in a sense a component of the total home care delivery system?

Ms. ZUCKER. Certainly; if both things existed, it would be best to go for it.

Senator BRADLEY. Thank you very much.

Now we will have Marilyn Zuchowski, Visiting Nurses Association, Somerset Valley.

Welcome to the Aging Committee, and please begin.

STATEMENT OF MARILYN ZUCHOWSKI, BRIDGEWATER, NJ, EXECUTIVE DIRECTOR, SOMERSET VALLEY VISITING NURSES ASSOCIATION

Ms. ZUCHOWSKI. Thank you, Senator Bradley.

My name is Marilyn Zuchowski, and I am the executive director of the Somerset Valley Visiting Nurse Association, a voluntary, nonprofit, home health agency in existence since 1948. I have been involved in home health care for 22 years, from staff nurse level to executive director. In the past 18 months, I have observed a significant decline in what home health benefits the Medicare Program will support.

I was very impressed in hearing the story of Mrs. Kennedy and her daughter, Mrs. Higham, regarding their denied home care benefits under Medicare. I applaud Mrs. Kennedy and her daughter, and also the other beneficiaries who testified today, for their willingness to offer their testimony and experience with the Medicare Program.

Recently, I was in the position of requesting a family's support and signature in appealing a noncoverage decision at the administrative law judge level. While this client and her family felt strongly that the noncoverage decision by the fiscal intermediary was wrong, they refused to participate or sign the appeal form as they

feared further retribution from the Medicare Program as it relates to future home health services. It seems to me that this represents a sad state of affairs in this country when our most vulnerable citizens feel they cannot exercise their rights for fear of retribution from their Government.

As we heard from Mrs. Kennedy and her daughter, home care benefits were denied her after less than 1 month of service from a home health agency. At the time that the fiscal intermediary denied nursing services to Mrs. Kennedy because the care was not skilled, she was experiencing a urinary tract infection and was suffering the side effects of dioxin toxicity. The nursing visits were denied because the fiscal intermediary felt that these services were neither medically reasonable or necessary, as the client's status was deemed stable. Such a decision was erroneous as Mrs. Kennedy's condition was not stable, and she required close monitoring of her medications and treatment of her many diagnoses, including uncontrolled diabetes. This decision is currently under appeal with the fiscal intermediary.

In some instances, Medicare home care benefits may be denied by the fiscal intermediary because the skilled nursing care does not meet the intermittent care requirement of the program. Basically, intermittent refers to the fact that services must be needed on a recurring basis. However, in recent months, the interpretation of intermittent care has been applied to mean less than daily care. The present guidelines allow for daily visits for a maximum of 3 weeks. In very exceptional circumstances, daily visits may be approved for an additional few weeks. What home health agencies are now faced with are inconsistent applications of these guidelines I just mentioned. For some clients who require daily service, the fiscal intermediary may deny coverage from the very first visit by declaring the client too sick to be eligible for home care.

As a result of very inconsistent interpretations of both skilled nursing and intermittent care by the intermediary, home health agencies are being forced more frequently to submit written appeals for a reconsideration review. The administrative time and energy expended in such appeals is increasing a home health agency's costs. For example, it recently cost my agency close to $250 in successfully appealing an unjust denial of service to one of my agency's clients. When one considers the increasing number of denials by the fiscal intermediary and the increased number of appeals being made by home health agencies, it is alarming as to what this process is going to cost the Medicare Program over the next year's period. Further, and more importantly, what price should be placed on the anxiety the Medicare beneficiary and the family experiences because of the uncertainty of receiving home health services under payment from Medicare?

On behalf of the patients we serve and the many, many home health agencies providing these services, I am most appreciative of the opportunity afforded me to share our concerns regarding the attempted dismantling of the Medicare home health benefits.

Thank you.

Senator BRADLEY. Thank you very much, Ms. Zuchowski, for your testimony.

I think that you are representing those people who are actually there on the delivery line. And I think your comments are particularly appropriate.

Just one question. We had earlier testimony from one of the witnesses regarding the denial of the payment because of a need for service for 5 days when only 3 days' coverage was allowed. Do you think it would make more sense if Medicare paid for 3 days of services and if the individual wanted to pay for the other 2 days, or the State had a program that would pay for the other 2 days, or the agency itself wanted to pay for the other 2 days, should that be permissible?

Ms. ZUCHOWSKI. I think that the Medicare Program should only be concerned with what they are paying for and not where other services are coming from.

Senator BRADLEY. OK.

The committee would now like to hear from Lois Hull from the Essex County Division on Aging.

Welcome to the committee, Ms. Hull. I know that you have served and are active on the delivery end of health services. We welcome you to the committee and look forward to hearing your testimony.

STATEMENT OF LOIS HULL, EAST ORANGE, NJ, DIRECTOR, ESSEX COUNTY DIVISION ON AGING

Ms. HULL. Thank you, Senator.

Thank you for convening this public hearing to gather information, as you have all morning, regarding the hardships currently being cause by HCFA decisions about the home care benefits under the Medicare Program.

I speak to you this morning on behalf of the 140,000 older adults in Essex County as the director of the Essex County Division on Aging, and also on behalf of the 21 Area Agencies on Aging, County Offices on Aging in New Jersey, as president of the New Jersey Association of Area Agencies on Aging.

The long-term care needs of older adults are as varied as is the diversity of the group itself. Medicare's increasingly rigid approach to allowable services is antithetical to the responsive delivery of those services. The continuing reliance on skilled care criteria and the focus on acute care is inappropriate at best. If we wish to serve a very rapidly growing elderly population, growing most quickly at the oldest end of the age spectrum, then we must introduce flexibility into the Medicare lexicon. Flexibility to allow for a range of care levels, for adjustable hours and days of service, and for elasticity in the duration of that service.

A recent experience at our division pointed up to us the severe limitations of existing Medicare policy. Mr. H is 97 years old. He and his wife, age 84, live together and alone in a small house here in the county. He has lived an exceedingly active and creative life. In recent years, a series of physical impairments have slowed his progress, but he continued to participate in a variety of civic and cultural projects up until he was scheduled for cataract surgery. Under Medicare guidelines, this is an outpatient procedure, not followed by any follow-up home care. Because of Mr. H's very fragile

physical condition, we sought and received the cooperation of his ophthalmologist in ensuring an overnight hospital stay. Upon discharge, his physician instructed that he remain at home for 6 to 8 weeks, which is unusual after this surgery. Our Division was able to supplement the care provided by Mrs. H with daily visits from a Home Friend. This is a program we administer, using Social Service block grant dollars, under contract with 10 community—based agencies. The service is nonemedical chore assistance. In this, and in more than 1,000 other cases this year, the Home Friend Program has made a significant difference in the ability of family care givers to continue to maintain a parent or grandparent at home, and in reducing unnecessary readmissions to acute care hospitals. It is frequently the only support available to the isolated older person. And it is not enough.

In New Jersey, the 21 Area Agencies on Aging constitute a unique network for information, referral, assessment, evaluation, advocacy, and service delivery. With limited resources and boundless enterprises, County Offices on Aging are picking up some of the pieces.

The Union County Office on Aging provides us with a good example of service coordination in their handling of the needs of a married couple, both in their eighties. Both suffer from diabetes, chronic heart conditions, and severe arthritis. The problem was referred to the Office on Aging after a series of hospitalizations which led to no skilled care follow-up and no home care. Through creative use of Social Services block grant funds and Older Americans Act services, the couple now receives approximately 20 hours of homemaking service a week and one nursing visit a month. In this case, it is sufficient to bolster their own abilities and to allow for continued independent living.

We suggest that the network established by the Older Americans Act, and in New Jersey supported by State legislation, is an effective and responsible vehicle for coordination of long-term care services.

We urge you and the Senate Aging Committee to seriously consider some of the recommendations in the recently issued Harvard Medicare Project Report and to explore the underutilized potential of the Area Agency network to improve and strengthen all home care services.

Thank you.

Senator BRADLEY. Thank you very much for your testimony and also for the great work that you do, and also that all of the Area Agencies throughout the State of New Jersey do.

One of the programs that I have a particular interest in is the Meals on Wheels Program which, as you know, delivers a hot meal to senior citizens. In many cases, it is the only hot meal that they get in a day. And it is also in many cases the only visit from the outside that they get.

I remember any number of times in Bergen County and Camden County and elsewhere where I have actually delivered the meals to the senior citizens and have seen for myself how important that program is.

Earlier there was a comment about--I think from Mr. Marosy—that he would recommend to exempt home care from Gramm-Rudman.

There is no doubt that Gramm-Rudman is going to, if it goes into effect, dramatically curtail the activities available to the Area Agencies. Within a couple of years, the Meals on Wheels Program could be cut in half—funds that are available for hot meals. I think it is extremely unwise, but we will not get into that now. Suffice it to say that Gramm-Rudman will fall on those who are least fortunate in our society.

I want to ask you about your idea of Area Agencies on Aging coordinating some of the home-care services. Now, as I understand it, Area Agencies have been involved in coordinating and directing nonmedical services. Do you see any kind of problem in coordinating services by Area Agencies because of the medical issues that you would have to deal with?

Ms. HULL. No, because we have always relied on the expert skills, wisdom, and knowledge of the professional in whatever relevant area we are dealing.

We have a program with the College of Dentistry. We do not make any decisions on prosthetic devices in people's mouths. We rely completely on their professional judgment. And we coordinate the service with other ancillary services. I believe that we have the capability if we are given the resources to do that with skilled nursing care. We would not propose to be, would not want the role of direct service provider at any time.

Senator BRADLEY. Thanks very much.

Let me say to the panel that I think it has been very helpful to have your contributions to this morning's hearing. The earlier panel of consumers of home health care left us all with a readiness to hear from those who are on the provider side about your suggestions on how to improve the delivery of services to the thousands of individuals across New Jersey who need these home care services so desperately.

Your comments, and the comments of Commissioner Perselay, Senator Lautenberg, and County Executive Shapiro, draw the necessary distinction between home care that is delivered in a long-term care setting and home care provided in a post-acute setting. I have been supportive of home care to meet the long-term care needs of the elderly, and I've actually gotten some provisions on this matter halfway into law once or twice in the last 2 years of budget stringency. I will continue to push for home care to meet long-term care needs because there is a very real need out there, one need that I believe should be financed by Medicare.

But the more specific problem that we dealt with in some depth today is that under existing Medicare law, certain home care services should be available for a certain population. Now, this service is not big in comparison to all of Medicare. Only 2 to 3 percent of the Medicare budget is now dedicated to these kinds of specific home care services.

And while I am aware that even though we have a giant budget deficit, I do not think that anyone in the Congress intended that the way you are going to get to a budget deficit down is by denying eligible and deserving seniors the right to some kind of home

health care, creating the serious personal trauma that we heard today from witness after witness.

Sometimes hearings are extremely helpful. This has been an extremely helpful hearing for me because it has focused on a broader question, and the broader question is really what do we owe another human being? Not only because they are part of our family, or not only because they are part of our neighborhood, but because they are simply human beings.

And I think that this warning today tells us that there are ways that we can dispense with that obligation with a certain dignity and honor and a certain caring that not only befits who we are as Americans, but who we are as individuals who care about other people.

And so I want to thank all of you for your testimony today, and again to the earlier witnesses who gave their personal testimony in such a powerful way, and say that when I go back to Washington, I intend to hold HCFA and their intermediaries to account. The system has been squeezed down unnecessarily and insensitively, and I intend to develop some legislation that will come out of this hearing that will force HCFA to loosen up. I am afraid if we do not do that, the administration is going to continue to try to solve their budget deficit by denying senior citizens the services that they deserve. We must make sure that Government, in conjunction with all of you, helps deliver the services that the elderly need.

So I want to thank you personally and as your Senator for your testimony, and to say that I believe that these policies are just not going to fly. We should stop this. We are going to stop this. You have been very helpful in giving me the ammunition I needed to define the problem. I had plenty of anger before; now I have a lot of ammunition as well.

Thank you very much. The hearing is closed.

[Applause.]

[Whereupon, at 11:30 a.m., the committee adjourned.]

APPENDIX

MATERIAL RELATED TO HEARING

Item 1

SUMMARY OF CLAIM DENIAL SURVEY

March 31, 1986

INTRODUCTION

A survey of NJ certified home health agencies was conducted by the Home Health Agency Assembly in April of 1986 to obtain information about the amount and kind of claim denials experienced by home health agencies in 1984, 1985, and the first quarter of 1986. A sample of twenty-six agencies (47%), representing a range of agency size, geographic area, and auspice category, completed and returned the questionnaires.

SURVEY RESULTS

NUMBER OF CLAIM DENIALS

Twenty agencies (77%) reported that they had seen an increase in the number of denials of Medicare home health care service claims in their agency in the past 12 months. Six agencies (23%) reported no increase.

The average number of claim denials, experienced by home health agencies, had increased from 20 in 1984 to 33 in 1985 - an increase of 65%. 1986 projections, based on first quarter experience, reveal that the trend is accelerating. If denials continue through 1986 at the same rate as in the first quarter, the average number of denials will increase to 75, representing a 127% increase. See Table 1.

Each claim denial represents service to an individual client. The number of visits denied in each claim may vary from a few visits to services rendered over many months. Some claim denials involve thousands of dollars.

The numbers of elderly patients being affected by these policies is substantial. Estimates of persons affected statewide (55 certified home health agencies) are:

1984 - 1100 persons (20 X 55)
1985 - 1815 persons (33 X 55)
1986 - 4125 persons (75 X 55)

CRITERIA MOST FREQUENTLY CITED FOR DENIAL

Failure to meet the criteria of skilled service was most frequently cited as the reason for denial, followed by patient not-homebound, care non-intermittent, selective billing, and service not reasonable for specific diagnosis. Table 2 describes rank order of reason for denial.

SERVICES MOST FREQUENTLY DENIED

Skilled nursing service was the most frequently mentioned type of service denied, followed by physical therapy, home health aide service, medical social work, and occupational therapy. See Table 3.

SUMMARY STATEMENT

A final question asked home health administrators to respond to the following statement:

"Over the past year, Medicare home health care claims denials have become so restrictive as to compromise the quality of care available to Medicare beneficiaries."

Seventeen (65%) indicated that they agreed strongly with the statement; 6 (23%) agreed; and one administrator (4%) disagreed. Two (8%) respondents qualified their statements to indicate that while quality of care was maintained, quantity of care, or scope of service, was severely compromised.

For Further Information contact:

Home Health Agency Assembly of New Jersey, Inc.

760 Alexander Road, CN-1
Princeton, NJ 08540

TABLE 1

NUMBER OF CLAIMS DENIED

AGENCY	1984	1985	1986*
1	-	-	-
2	28	92	240
3	56	148	92
4	-	-	104
5	-	-	-
6	4	6	8
7	7	13	148
8	16	21	44
9	6	8	8
10	9	7	64
11	-	28	68
12	-	15	48
13	-	-	224
14	-	2	-
15	-	(1062 visits)	(916 visits)
16	10	25	24
17	(373 visits)	(801 visits)	(1412 visits)
18	-	29	44
19	10	23	40
20	(135 visits)	(143 visits)	-
21	-	-	-
22	68	59	-
23	-	-	-
24	3	5	24
25	-	-	-
26	29	39	24
Total	246	520	1204
Number	(N=12)	(N=16)	(N=16)
Average	20	33	75
Annual % Increase		65%	127%

* 1986 denials projected from first quarter reports.

TABLE 2

CRITERIA MOST FREQUENTLY CITED FOR DENIAL

(In rank order of frequency, weighted response)

Weight Scale

Rank	Weight
1	6
2	5
3	4
4	3
5	2
6	1

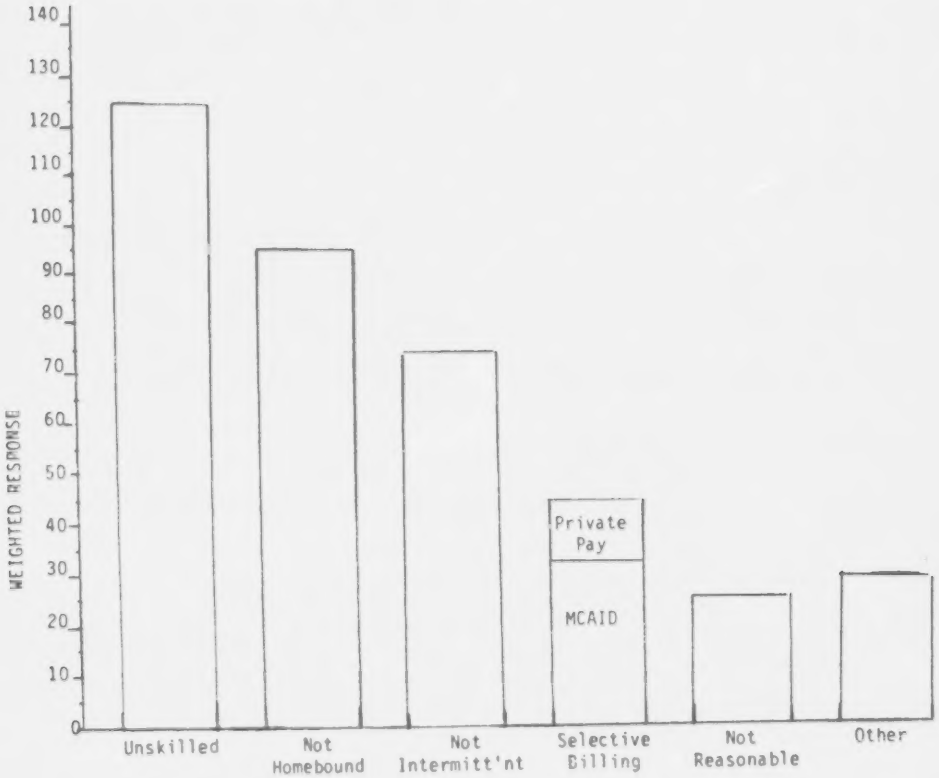


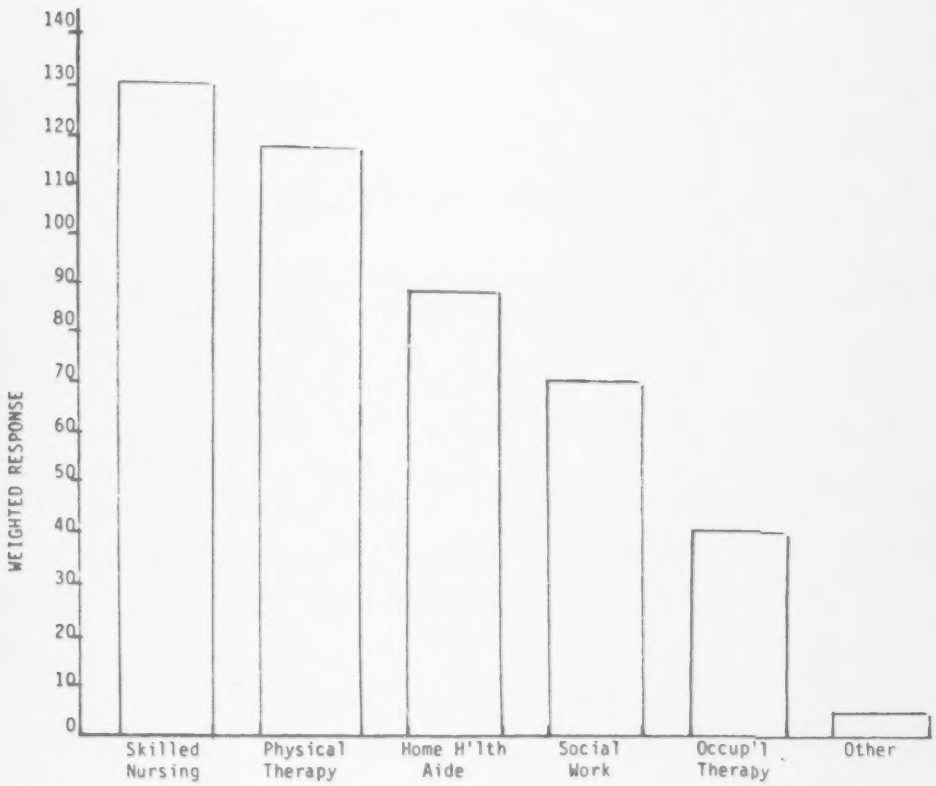
TABLE 3

SERVICES MOST FREQUENTLY DENIED

(In rank order of frequency, weighted response)

Weight Scale

Rank	Weight
1	6
2	5
3	4
4	3
5	2
6	1



HOME HEALTH AGENCY ASSEMBLY OF NEW JERSEY, INC.
760 Alexander Road CN-1 • Princeton, New Jersey 08540

Center for Health Affairs
(609) 452-9280

SUMMARY OF CLAIMS DENIALS AND WAIVER OF LIABILITY SURVEY

Completed surveys were received from 36 home health agencies, representing all agency auspices - 13 public, 14 free-standing, 7 hospital-based, 1 proprietary, and 1 combined public/free-standing. Agency size, as measured by volume of Medicare visits, was representative of agency distribution, statewide. Of the 36 responding agencies, 32 used Prudential as their fiscal intermediary, 2 used Blue Cross of New Jersey, one used Blue Cross of Michigan, and one no answer.

MAGNITUDE OF PROBLEM

It is apparent from the survey responses that home health agencies in New Jersey have experienced an unusual and alarming increase in loss of waiver of liability and claims denials in the past year (since January, 1984). Fouteen agencies (39%) reported loss of waiver of liability. Moreover, 26 (72%) report an increase in denials over the past six months, as compared to the same period, one year ago. The rate of increase in claim denials varied from under 10% to over 100%.

DENIAL AREAS

Most agencies who experienced an increase in denials were able to identify particular service plans for which more denials were found that others. Home health aide, physical therapy, daily nursing and medical social work were the most frequently reported denial services.

Sixteen agencies cited denials for home health aide service in excess of 3 days/2 hrs per week. Fourteen agencies experienced denials for PT (and other therapies), usually in extended rehabilitation situations. Daily nursing, especially for wound care requiring daily dressing change, was identifed by 10 agencies. Social work denials were reported by 9 agencies. Denials for aide and nursing services deemed 'maintenance' as opposed to 'skilled' was described by three agencies. Other reported denials included visits for Vitamine B 12 injections, denials on 'homebound' status, and denials for nursing visits close to dicharge.

ADDED COSTS

While the costs associated with denials and waiver of liability are insidious and difficult to quantify, a significant number of agencies were able to identify specific cost increases directly related to these activities.

ADDITIONAL STAFF
Nineteen agencies reported the hiring of 8.3 FTE nurses and 12.4 clerical staff specifically to deal with increased record review, documentation, and reporting activities resulting from denials. A total cost of $330,240 - $177,875, nursing; $153,149, clerical - was incurred by the 19 agencies, or an average of $17,381.05 per agency.

OVERTIME
Twelve agencies stated that they definitely had incurred overtime expenses in satisfying the documentation requests of their fiscal intermediary. The average overtime cost of the agencies who had broken out this expense was $7000.

COPYING EQUIPMENT AND SUPPLIES
In most cases, copying and materials expenses refer to the per unit increases brought about by the additional documentation requirements. However, five agencies reported that the extra demand overloaded their copier capacity and they had to purchase a new copier. Nineteen agencies identified either per unit, supplies, or equipment costs directly related to increased regulations for ducumentation. Total reported costs were $61,327 or an average of $3227.74 per agency.

Based on these reported costs, the average agency incurred expenses of $27,608.79 in responding to fiscal intermediary claim denials.

Additional staff	$17,381.05
Overtime	7,000.00
Copying/materials	3,227.74
	$27,608.79

OTHER COSTS
Many survey responders pointed out that the most important cost of excessive documentation is calculated not in dollars and cents but in quality of care. Excessive documentation requirements reduce the time available for patient visits and staff supervision which are the guarantees of quality service. Likewise, the time and energy of administrators is distracted from creative activities by paperwork demands, to the ultimate detriment of the home care patient.

June 1, 1985

1984 Home Health Data Report, Home Health Agency Assembly of N.J., Inc.

INTRODUCTION

This report presents 1984 data from certified home health agencies in New Jersey and examines trends in agency characteristics and service utilization between 1980 and 1984. For historical perspective, reference is made to the 1983 Home Health Data Report, which shows industry trends between 1980 and 1983. Copies are available from the Home Health Agency Assembly of New Jersey.

New Jersey has a mature and progressive home health industry. Accessibility to service, as measured by the Medicare use rate, places New Jersey among the top ranking states. With a Medicare use rate of 50.3 (per thousand Medicare enrollees), New Jersey ranks 9th in the nation. The average Medicare use rate nationwide is 39.7, ranging from a high of 65.7 in Vermont to a low of 14.3 in Alaska.(1) At the same time, per visit charges in New Jersey remain substantially below the national average. In 1984 the US average per visit charge was $45.65, while the average charge in New Jersey was $37.77, a per visit difference of $7.88. (2) The achievement of high use and moderate cost is a very desirable objective, which occurs when the conditions of access, availability, and efficient managment are present.

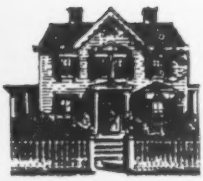
Recent federal health care policies aimed at cost reduction are affecting the home health environment and the New Jersey 1984 data reflect the impact of these changes. For the first year since statewide data has been collected, there was no growth in the number of client admissions, although the number of certified agencies increased from 51 to 55. There were fewer visits per patient in all discipline areas (except occupational therapy) due to tightened eligibility criteria in the Medicare program. However, the total number of patient visits increased by 8% because more clients were admitted with complex needs requiring multi-discipline services.

The home health data base developed in New Jersey is a cooperative effort between the Home Health Agency Assembly and the New Jersey State Department of Health. Both the state and the industry recognize the importance of careful tracking of home health use in the present environment of change. Awareness of the interdependence of all parts of the health care system is fundamental to enlightened health policy. The 1984 Home Health Agency Survey draws attention to the rippling effect that changes in federal policies regarding Medicare benefit criteria or hospital reimbursements have on the use of home health services.

1. Medicare Program Statistics Branch, Office of Research and Demonstration, and Buearu of Data Management and Strategy, HCFA.
2. Bureau of Data Management and Strategy, Health Care Financing Administration, Medicare Data: Current Utilization Tables, December 28, 1984.

Copies of the full report are available by writing to 760 Alexander Road, Princeton, NJ 08540

Item 2



Neighborhood Association of Millburn Township

VISITING NURSE SERVICE DAY NURSERY SCHOOL

FOUNDED BY MRS. STEWART HARTSHORN IN 1894

12 TAYLOR STREET MILLBURN, N. J. 07041

April 18, 1986

Dear Senator Bradley:

The following example of inappropriate denial of medicare services to patients is presented in order that it may be read into the record for the United States Senate Committee on Aging to review.

An eighty-six year old patient, casted from knee to toes, was receiving physical therapy treatments to increase muscle strength of the affected limb and to achieve incremental levels of weight bearing per the physician's orders until the cast was removed.

The reason given by Prudential, the fiscal intermediary, for the denial of physical therapy services was that the patient had a leg cast and therefore physical therapy was inappropriate. The assumption that a cast automatically rules out physical therapy is being applied more frequently as are denials based on diagnosis only. These denials are being made before a patient's record is reviewed. The attachments to this letter include the home health agency's response to a telephone denial from Prudential and Prudential's subsequent written rationale for the denial. To date no response to the request for reconsideration has been received.

I hope this example helps identify the way benefits are being reduced through changes in interpretation of what constitutes appropriate medicare services.

Very truly yours,

Judith Gordon

Judith Gordon, R.N., M.A.
Executive Director

enclosures: 2

Neighborhood Association of Millburn Township
VISITING NURSE SERVICE DAY NURSERY SCHOOL
FAMILY COUNSELING
12 TAYLOR STREET, MILLBURN, N.J. 07041 (201)376-0433

April 5, 1986

Irene Williams
The Prudential Insurance Co.
P.O. Box 7000
Millville, N.J. 08332

Re: Maxwell Potruch
HIC: 8605512737
Denial of Physical Therapy
Service after 12/1/85.

Dear Ms. Williams:

I am writing to give you added information as to why services were needed and appropriate after 12/1/85.

Mr. Potruch is an 86 year old man who was casted from the knee to the toes of the left lower extremity. He has a history of coronary artery disease with pacemaker, he wears a hearing aid and has had cataract surgery. Due to his age and multiple disabilities and the strangeness of the cast, he had difficulty understanding the principles of safe partial weight bearing on the left lower extremity. To avoid a possible accident and potential disruption of the healing fracture, additional training sessions were required. This is the reason for the visits on 12/3 and 12/5/85.

He was subsequently put on a hold status until the weight bearing status was changed to full weight bearing. At that time which was 12/17/85, he was again restarted on physical therapy for the purpose of training him in safe proper stair climbing, and full weight bearing ambulation with the cast.

Treatment and training continued until the cast was removed on 1/6/86. Subsequent visits were directed at improving left ankle and foot range of motion, strength and skin condition. The patient was discharged on 1/18/86.

I hope the above aids in clarifying the need for the physical therapy visits after 12/1/85. I await your favorable reply.

Very truly yours,

Gerald Weiss,
Registered Physical Therapist

GW/nm

Notice of Medicare Claim Determination

Intermediary Number, Name and Address
53310
The Prudential Insurance Company of America
P.O. Box 7000
Millville, New Jersey 08332

Date APR 16 1986
April 10, 1986

Your Health Insurance Claim No.
092-10-8152-A

Maxwell Potruch
140 Glenview Road
So. Orange, NJ 07079

Services Provided By (Name and Address)
Neigh. Assoc. Millburn

Provider Number
317039

Type of Service Provided	Date of Admission or First Visit	NOTICE COVERS PERIOD	
		FROM	THROUGH
☐ Hospital ☐ Skilled Nursing Facility	10/31/85		
☐ Home Health Agency ☐ Other _____	Insurance: ☒ Hospital ☐ Medical	12/01/85	12/31/85

This concerns the services you received from the facility shown above. Medicare cannot pay for part of these services for the following reason:

An individual is eligible for physical therapy only if the physical therapy involves a type of treatment or procedure that requires the specialized knowledge, and training of a qualified physical therapist. For Medicare purposes, it is intended for patients whose level of function has been reduced or lost because of an illness or injury, but have, in the opinion of a physician, potential for improvement through active physical therapy. The services must be given according to a plan of treatment written by a physician who determines the patient's need, capacity, and tolerance for therapy, the treatment objective and at what point the therapy is no longer needed.

Patients who may have needed and received physical therapy because of an illness or injury, can usually be expected to reach a point where their condition will no longer be noticeably improved with continued physical therapy. When this level is reached, Medicare can no longer help pay for the physical therapy services.

Beginning with 12/01/85 the records show you were not receiving the type of care that is reimbursable as physical therapy under Medicare.

Effective October 31, 1972 a provision of the law permits payment if neither the beneficiary nor the provider knew that payment could not be made for such non-covered services. Therefore, payment is being made by Medicare from 12/01/85 through 1/06/85, except for the deductible or coinsurance amounts that might apply.

Effective with this notice the waiver of liability will not be extended to you or the above-named provider on future cases involving this particular or similar type of service or modality.

Important: See other side for an explanation of your appeal rights and other information ▶

Form HCFA-1955 (6-83) (formerly SSA-1955) 1-BENEFICIARY COPY 2-PROVIDER COPY 3-INTERMEDIARY COPY

NO. 22

Item 3

Visiting Nurse Association
in Middlesex County, Inc.

CN 6009 • 1915 OLD GEORGES ROAD • NORTH BRUNSWICK, N.J. 08902
(201) 821-9500 or (201) 826-6664

MAUREEN GILLIGAN, R.N., M.A.
Executive Director

April 18, 1986

Senator Bill Bradley
Hart Building
Washington, D.C.

Re: Medical Social Service Under Medicare in Home Care

Dear Senator:

The following comments are being submitted in conjunction with the hearing to be held in Newark on April 21, 1986. My views are unique to the problem as they pertain to a less vocal population - the Medical Social Worker in Home Care. They also encompass an even less visable population - those patients we represent who are being made more and more vulnerable by "the system". As you know, nursing and homemaker services have been severely cut during recent years to Medicare recipients. A more recent trend over the past few months has been to also cut back on provision of medical social services. Therefore, patients are not only losing their much needed medical care but they are also losing their advocates to obtain necessary community services to assist them in remaining in their own homes.

Since September 1985, a new form is required by HCFA and must be submitted on all patients to our fiscal intermediary - Prundential. HCFA provided scanty guidelines in relation to social services. I have been at the Visiting Nurse Association in Middlesex County for nine years. The nature of how my staff has provided social services has not changed. Between 1977 and 1985, Medicare only denied .003% of our Medical Social Service claims. Since this new form was instituted, they have denied over 25%. We were told there would be a "grace period" so we could make necessary adjustments. This has not occurred.

The main problem is in inconsistencies of interpretation of the "guidelines for Medical Social Services". The only reason we are usually given is that the MSS provided did not have significant impact on the patient's medical condition. This has forced us to direct our efforts toward improvement in how to fill out the form so clerks (not trained Social Workers) can understand what we do. Thus, most of my time is spent justifying the service, not providing it! This has affected the quantity of social services as it has caused my agency, a non-profit organization, to cut back on the number of visits being made.

A Nationwide Task Force of Home Care Social Workers through NASW, has been working with HCFA representatives to improve upon the role of Medical Social Services and have apparently succeeded in expanding upon the codes supposed to be approved by the fiscal intermediaries. Yet, our regional fiscal intermediary has not received word yet from HCFA of these clarifications. Meanwhile, if denials continue at this rate, by the time any positive change is made, the social service department will be dissolved. A non-profit organization cannot afford to wait around for this lengthy bureaucratic process.

I ask that you assist us in putting a halt to this squeeze play. I am aware of the games being played. I am a professional caught in a catch 22 situation and I am feeling as helpless as my patients in how to best advocate for change. I feel strongly that Medical Social Services should remain as a service covered under Medicare for Home Care. At the current rate of denials, it won't be.

If I can provide any further information that will assist you, please let me know.

Thank you for your anticipated cooperation in looking into this matter.

Sincerely yours,

Suzanne C. Mundhenk, ACSW.

Suzanne C. Mundhenk, ACSW
Social Work Supervisor

SM/ev

Item 4

Angela A. Iuso
27 Bradford Avenue
West Orange, New Jersey 07052
(201) 731-8077

April 18, 1986

Senator Bill Bradley

Dear Senator:

I take this opportunity to express the role that social services have played in the lives of an entire family.

Due to a stroke which resulted in paralysis of the entire left side, my grandmother has been taken in by her daughter, my mother. This tragedy has resulted in continued emotional distress and tension upon an entire family which is seeking to each contribute to the constant day and night care of our family member. As a large working family, my mother is left alone with my grandmother on a daily basis anxiously awaiting the arrival of a home health aid who is trained to properly bathe, feed and care for a patient who has been confined to bed with a feeding tube for 8 months thus far. Two people are needed to raise her onto a chair so that her back can be properly cared for and so that the bed can be changed.

Discontinued services by Medicare has resulted in great trauma to the entire situation as the health aid is not afforded nearly enough time to properly care for the patient or to alleviate the tensions of the family members. I cannot stress enough how such a trivial contribution on the part of Medicare has been able to result in such immense help to our family. Reinstatement of these Medicare services would be of tremendous value to our patient and her family.

This area demands immediate attention and remedy as an increasing number of elderly people become abandoned due to a lack of services.

I welcome any comment or response you may have. Thank you for your time and consideration.

Sincerely,

Angela A. Iuso

AAI:kml

Item 5

SENIOR CITIZENS COUNCIL OF UNION COUNTY, N. J., INC.

2165 MORRIS AVENUE
UNION, NEW JERSEY 07083
TEL. (201) 964-7855

EVELYN FRANK, PRESIDENT

April 21, 1986

This is a joint statement by Evelyn Frank, President of the Senior Citizens Council of Union County and Peter Shields, Delegate-at-Large of the Council and founder of the New Jersey Leadership Council on Aging.

Our Union County Council represents 12,000 older citizens from over 50 senior groups. We are also the advocate for 95,000 senior citizens of our county.

We protest all that is happening that is bad for Home Health Care under Medicare, and all that is not happening that should be done to improve Home Health Care.

It was intended by Congress that the Medicare Program would provide us with health care security. It was a promise and a commitment that is not being met.

Today we find the adminstrators doing all they possibly can to curtail medicare benfits to our detriment. Cuts in this area of Home Care are wasteful, penny wise, and pound foolish.

We cannot believe that "Cost savings" applied to Home Care really saves the taxpayer money. The so called savings are more than used up in nursing home care which might have been avoided through adequate home care.

We leave it up to the Visiting Nurses to cite the sad plight involved in their becoming pencil pushers trying to justify why their patients need care and we leave it up to the few family members and patients who can testify as to their unmet needs. We join with them to add our voice of protest on behalf of our 12,000 members and call upon our legislators to correct these inequities now.

Attached herewith is a resolution which will be passed at our Annual Meeting next month which will reflect the vote of our members on this issue.

Evelyn Frank Evelyn Frank
President/Director

Peter Shields Peter Shields
Delegate-at-Large

WHEREAS, it has come to the attention of the members of the Senior Citizens Council of Union County that patients are being discharged from hospitals "Sicker and and Quicker" under current DRG (Diagnostic Related Groups) system, and

WHEREAS, there is a need for a determination of the level of post hospital care needed as well as a guarantee that discharged patients got the follow-up care they need nneed, and

WHEREAS, there is a need for hospitals participating in Medicare to have discharge planners work with attending physician to develop a care plan past the point of discharge, and

WHEREAS, peer-review organizations in the DRG system should have authority to monitor the discharge process which would guarantee proper follow-up care and,

WHEREAS, all Medicare patients should be clearly apprised of their rights at the point of discharge.

NOW, THEREFORE, BE IT RESOLVED that we the members of the Senior Citizens Council of Union County should resolve that both the federal Senate and House of Representatives should now take action to initiate and arrange for the passage of legislation that would correct the afore mentioned inequities.

Item 6

STATEMENT OF
JERSEY ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS

UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING
FIELD HEARING
NEWARK, NEW JERSEY
APRIL 21, 1986

THE EROSION OF THE HOME CARE BENEFIT

The Jersey Association of Medical Equipment Suppliers (JAMES) is a non-profit trade association representing suppliers of Durable Medical Equipment (DME) under Part B of Medicare. On behalf of our members, we would like to thank the Committee for focusing attention on the growing importance of home health care for the elderly. Our members are increasingly concerned about reductions in program administrative funding and numerous, uncoordinated program changes which have led to significant reimbursement delays and confused beneficiaries, carriers and suppliers alike.

JAMES strongly supports adequate funding for the administrative expenses incurred by Medicare carriers and intermediaries. Our members feel that it is unrealistic to expect firms charged with administering Medicare programs to absorb the costs associated with increased claims volume, particularly at a time when these firms, as well as providers and suppliers, are being asked to make huge investments in electronic claims processing hardware and software. Inadequate support for carriers at this critical time is unrealistic and has brought Medicare's reimbursement system and suppliers under Part B virtually to the point of collapse.

The 1980s have been a time of reassessment and change for healthcare. Modalities and structures that served Medicare since 1965 have been reevaluated and, in some instances, totally discarded, in favor of newer approaches meeting new objectives. Many of these changes were timely and desirable; the Diagnostic Related Groups (DRGs) are but one example.

The DRGs were a reasoned approach to correct the problems inherent in cost-based reimbursement and, by and large, have been responsibly implemented in ways that permitted Congressional and industry input both in design and implementation. Unfortunately, this open, reasoned approach to social policy development has not been extended beyond Part A to the Durable Medical Equipment (DME) suppliers, physicians and others who provide equipment and services under Part B.

The reasonable charge methodology under Part B, like the old cost-based reimbursement for hospitals, may be inappropriate now, 20 years later. It is said to be inherently inflationary and ill conforming to recent changes in the marketplace. Unfortunately, rather than seek reasoned, consistent legislative changes, the Administration has resorted to a series of ad hoc, uncoordinated changes designed to change the fabric of the Part B reimbursement methodology without Congressional or industry consultation. In the last 12 months, we have seen eight major administrative initiatives applied to the DME industry:

- o the Common Procedure Coding System,
- o the rent/purchase program,
- o various PATROL/VAP initiatives,
- o the "inherently reasonable" criteria,
- o a freeze in FY 1986 reimbursement,
- o the Oxygen guidelines,
- o proposed national rates for parenteral and enteral nutrition, and
- o the February 18, 1986, proposed rule under which HCFA accords itself virtually unfettered authority to establish whatever price it chooses for DME and physician services.

The impact of these ad hoc changes on carriers and suppliers alike has been devastating:

- o Numerous DME suppliers now report Medicare accounts receivable exceeding 120 days, causing severe cash flow problems and, in some cases, documented bankruptcies.

- o Carrier statistics, which show increases in Days Work On Hand, do not accurately reflect the magnitude of the problem, both because the average of all Part B claims outstanding (including physicians) does not accurately reflect the significantly larger than average backlog of DME claims, and because these reports do not take into account thousands of claims which have not been entered into the processing system at all. Too often, claims are simply thrown away or left to gather dust.

- o Carriers either have been or will be reducing staff levels essential to the timely processing of claims.

- o The incentives for large investments in electronic claims media (ECM), which will save time and money over the long run, are being reduced.

- o New providers and suppliers entering the field can expect serious cash flow problems which will threaten their ability to provide quality health care. If these conditions persist,

competition will be reduced.

- Fewer providers and suppliers will be willing to accept assignment and wait 120 days for reimbursement, thereby shifting financial burdens to beneficiaries, many of whom will be unable to pay for the services and equipment essential to their health and well-being.

To be candid, we are not exaggerating when we say that reimbursement delays are already curtailing our industry's ability to provide equipment and services. We cannot pay our bills. We are borrowing money to meet current financial obligations. And, some dealers have been forced to seek protection under Chapter 11.

Our carriers are grappling with the same problems as best they can. Budget constraints and increasing workloads are a fact of daily life and likely to remain so in the absence of clear Congressional action. It is clear that the Administration is unwilling or unable to address the problem.

We recommend the following action:

- Increase appropriations for claims processing.

- If increased appropriations for claims processing are not possible, then make some arrangement whereby claims not processed within 30 days will be paid and <u>subsequently</u> audited with later adjustments for over- or under-payments.

- The ultimate solution to many of the problems confronting carriers, suppliers and beneficiaries lies in a systematic legislative change of the current Part B methodology. We acknowledge the need for reasoned, carefully constructed changes in Part B and we respectfully propose a six-point plan of action currently under development by the National Association of Medical Equipment suppliers. It is designed to correct problems in the DME portion of Part B. Our recommendations follow:

  1. Retain the current rent/purchase methodology for inexpensive equipment, e.g., items costing less than $120.

  2. Establish three categories for expensive equipment:

     - Category A: <u>Unlimited Rental</u> of high-risk or service-intensive equipment, e.g., respiratory equipment.

     - Category B: <u>Rental</u> of other equipment, but capped in terms of a number of months, e.g., hospital beds.

- o Category C: Defined exceptions where purchase is appropriate, e.g., customized equipment, consumables and disposables.

3. Establish a national pricing system which moves away from the historical reasonable charge methodology and toward a system of adjustments tied to the Consumer Price Index.

4. Establish a small "ProPAC"-type advisory committee to review DME reimbursement levels and recommend appropriate adjustments, either upward or downward.

5. Reduce the number of carriers servicing DME beneficiaries and suppliers.

6. Uniformly enforce the collection of co-insurance and deductibles.

We feel that adoption of such a program would correct many of the problems currently confronting suppliers and beneficiaries. In addition, we feel that such a program would eliminate the need for the current $1.5 million competitive bidding project now being conducted by HCFA through Abt Associates. JAMES members question the need for this project. Their concern is based on the potential for reduced competition in the marketplace which could result if losing bidders are forced out of business. If losing bidders are allowed to participate, there is little or no incentive for suppliers to bid low. This, coupled with the fact that DME Medicare reimbursements currently are frozen at 1983 levels, begs the question of why HCFA is spending so much on this project in this time of fiscal austerity. Of particular concern to JAMES members is the potential for reduced equipment quality and service which could threaten the quality of patient care.

Yet another concern is that there is no appeals mechanism for Part B beneficiaries other than a fair hearing conducted by the Medicare carrier. As a result, HCFA has issued numerous transmittals and directives that our members feel are in violation of the law. JAMES strongly supports passage of S. 1551 and H.R. 2864. Both bills would enable beneficiaries and suppliers to gain access to judicial review through Administrative Law Judges and Federal District Courts.

Mr. Chairman, Members of the Committee, thank you for the opportunity to discuss this pressing problem. Our association stands ready to work with Congress and the Administration in a mutual effort to correct deficiencies in the Part B program. All of us share a profound responsibility in our efforts to provide quality health care to the nation's poor and elderly.

Respectfully submitted,

Sheldon J. Cohen, President
Jersey Association of Medical
Equipment Suppliers
308 Talmadge Road
Edison, New Jersey 08817

Item 7

NJSNA

609-392-4884

New Jersey State Nurses Association

Mary Germain, Ed.D., R.N.
President
Barbara Wright, M.A., R.N.
Executive Director

Dangers and Disadvantages of Medicare Home Health Care Cuts

written testimony for

US Senate Committee on Aging

through Senator Bill Bradley

by:

Paula Cell, MPH, RN, Chairperson,

Division of Community Health Nursing, NJSNA

and Director of Nursing, Visiting Nurse Association of Trenton,

Held on April 21, 1986

Newark, NJ

320 West State Street, Trenton, New Jersey 08618

Nurses alarmed about impact of patient care Medicare Cuts:

On behalf of the New Jersey State Nurses Association the organization for professional nurses, and the Community Health Nursing Division which is composed of nurses practicing in the home and community, we wish to report our alarm about the continued Medicare cuts in home care services. Home care nurses face dilemmas daily knowing of the denials for services looming over their practice and the growing number of patients falling into the no-care zone.

Frequently, we hear expressions of anger and frustration, and find ourselves listening to story after story of functional limitations on intermittent care for the homebound. We want to address the issues of cut-backs and stringent adherence to the Medicare Guidelines using the experience I have had in my agency, as Director of Nursing at the VNA of Trenton. This large and growing agency has prided itself in the fact that the nurses were justifying five and seven day home health placements with good documentation of need; that orders for dressing changes as frequently as three times a day were passing the scrutiny of the fiscal intermediary; and that social service visits to families with serious interpersonal conflicts were accepted for reimbursement. But in January, 1985, the boom fell. Our waiver was removed because we had a denial rate of more that 5.0% of our claims.

With this crisis we had to go to the nursing staff with an appeal to limit home health coverage to three days for three hours; to get back to physicians who were ordering three dressing changes daily to order daily dressings; and to suggest that when the family situation was dysfunctional and they needed help from the social worker, they would be advised to solve the problems without involving a home visit by social service staff. In other words, we were asking the nursing staff to base clinical judgments on the restrictions placed on them by the fiscal intermediary, rather than on their professional expertise.

Nurses must cut necessary care:

The nurses went to their patients who needed seven day home health placement to tell the family they would have to pay for home health service given, when greater than that permitted. They called the physicians to ask if dressing changes might be limited to daily applications, and they spent hours with the social workers discussing approaches to helping caretakers manage their chronically disabled relatives with personal assistance from friends and other family. Occasionally they purchased homemaker service to relieve the burden of twenty-four hour care.

The nurses implemented these suggestions made by the Medicare

administration and the agency had its waiver restored within six months. But there has been a price to pay for this privilege -- the nurses are angry because they believe that the real needs of the patients do not seem to be the critical factor that determines what the plan of care shall be. Also the nurses are discouraged by the continuing concern that if they make a mistake in judgment, the agency will lose its revenue.

In the process of evaluating our options during this time, and designing a course of action to remedy the situation, we all learned at least three things: 1) one cannot really learn the rules without first breaking them; 2) that the staff nurse is caught in the middle having to make choices for the patient and family which are often not in the patient's interest; and 3) that no one wins. The nurse may provide just enough care to be reimbursed without questions by the fiscal intermediary, so that the agency will not have claims denied, and thus is financially secure. But the patient and family may be left to buy needed service at a cost they cannot afford. Patients and families are encouraged by the system to spend-down, so that they might, in time, be eligible for service under Medicaid.

Nurses practice intimidated by severe restraints:

In a home health agency, the staff nurse functions as "gate keeper" of the gate through which most patients gain access to community health services. She is case manager, care provider, educator, and purveyor of information about what is available to the patient in his home, who will provide the care, and how long this care will last. So at the time of intake, the nurse screens the calls for appropriateness. That is, will the physical needs of the patient fit the criteria for reimbursement. Ninety percent of the time the care being ordered will be covered and the amount of service required will meet the short-term needs of the patient. The nurse will give the care, or she will refer the patient to therapy for service. The patient's condition will improve. The patient can be discharged and the nurse or therapist can take satisfaction in the recognition that she or he has made a difference.

But what of the other ten percent? It is very disheartening to the nurse to have to say to the hospital discharge planner: "If Mr. J's skin lesions require extensive re-dressing three times a day, the Visiting Nurses' Association may not accept the case because there is no reimbursement. His care is not considered intermittent." The nurse is left with the nagging sense that she has failed the agency because she has had to turn a case away; and she has to worry about what recourse the family will have to get care for the patient.

Case examples demonstrate the problem:

Then, there is the problem presented by Mrs. T who has been seen by her physician and found to have a blood sugar of 300+, more than two times the normal level. The physician asks the visiting nurse to make a home visit to teach Mrs. T to give her newly prescribed insulin. The physician also asks the nurse to teach the woman about all aspects of her disease including diet and skin care. What the physician does not realize when he makes this referral is that because he has not admitted this woman to the hospital for further testing, and to stabilize her diabetes, he has restricted her access to community health nursing. Thus, he has limited the assistance she needs to learn to care for her disease. In this particular situation, the woman was seen in the office, taught to give herself insulin, and given as much instruction about her disease as was possible within this less than perfect setting. This care was covered by funds from United Way, not Medicare. The intake nurse was creative and very responsible about the response to this call, but the precious resource of United Way funding was used because this woman was technically, not homebound.

In addition, perhaps more frustrating that anything to the intake nurse, was the call from a physician who is caring for an elderly patient with severe osteoarthritis. She has been hospitalized for evaluation of a fall, but is soon sent home without significant treatment. The family wants care for the patient because she is difficult to manage. The physician knows that the condition is chronic and that there is little available in the way of reimbursable skilled care, but cannot confront the patient and family directly with the dilemma. Therefore, he refers the patient to the VNA for evaluation. The nurse makes one visit, but cannot justify more visits because the condition is chronic and stable. Thus, the nurse must explain the rules of Medicare coverage to the family, and accept the blame for a callous approach to the patient and family. She feels the guilt for a system which is not serving the needs of the patients she sees every day.

So the nurse is caught in the middle between the patient and the decisions she must make as a responsible nurse; the family and their need to have answers about service; and the absolute necessity to remain involved with the patient until she can be assured that she has done all she can do to provide a safe environment. Until recently the social worker was her ally. When the level of service required was greater than the resources and/or the mission of the VNA, Social Service could make one or two visits, put the family and patient in touch with other community agencies, and thus facilitate the process of discharging the patients. However, the stringent review and rejection of claims for social service has made this service very expensive for the agency and thus vulnerable. The staff nurse, then,

already overburdened with paperwork and a heavy caseload with very sick people, has to provide this consultation on available community resources, the length of her visit goes up, her overall productivity goes down, and she is getting caught in a burn-out cycle.

Nurses "burn-out" trying to meet care needs:

I have briefly discussed the "soft" effects of the Medicare cuts on the delivery of home care; the frustration and anger the nurse feels every time she gets caught in the middle of a decision which hurts the patient or family. But these "soft" effects translate into the "hard" reality that illness and absenteeism are up; that committed community health nurses are leaving the specialty; and that the independent practice of community health nursing has become to heavy a burden.

Home care, with the nurse functioning as care giver, teacher, manager and patient advocate, is a cost of effective way to keep the elderly or disabled person at home but the restrictions cited are limiting use of home care and more people are falling into the no-care zone.

PC:tmd
d/556

Item 8

LEGISLATIVE MEMORANDUM

CancerCare, Inc.

AND THE NATIONAL CANCER FOUNDATION, INC.®

William C. Pfeiffer
Chairman, Public Affairs Committee

Warner Wetzsteon
Vice Chairman, Public Affairs Committee

Doris B. Nash
Public Affairs Director

April 21, 1986

To: Senator Bill Bradley
U.S. Senate Committee on Aging

Re: The Condition of Medicare's Home Health Care Benefit

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Donald E. Carrine
Executive Director

We wish first to commend you for holding a hearing on the "dismantling" of Medicare's home health care benefit and its impact on New Jerseyans. This is an extremely urgent issue, one that needs as much exposure as possible.

In lieu of presenting oral testimony, we are submitting this statement about our New Jersey social workers' experience with Medicare's home health benefits. We trust our statement will be given full consideration and will be part of the official record of the hearing.

Cancer Care, Inc. is a voluntary agency - now in its 42nd year - providing comprehensive social services to cancer patients and their families. Individual and group counseling are available for patients and their relatives, as well as bereavement counseling. In addition to helping families plan for the patient's care at home, some financial assistance is available to eligible self-supporting but needy families to help them pay for home care plans and transportation costs to and from chemo and radiation therapies. It is this latter aspect of our services that provides us with so much experience and knowledge of what is happening with Medicare's home health services.

Since opening our office in New Jersey over 2 years ago, the call on our services there has increased dramatically! During our '84-'85 fiscal year, New Jersey patients comprised 14.4% of Cancer Care's total caseload (9,984 patients) and utilized 23.3% ($200,976) of our total disbursement funds of $864,320. Statistics for the first 6 months of our current fiscal year reveal that New Jersey now represents 20% of the total caseload and 28% of the agency's disbursements. The New Jersey office is currently receiving about 190 requests for help each month. It is projected that New Jersey disbursements for the full year will probably amount to $230,000. Our caseload in New Jersey

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1180 Avenue of the Americas
New York, N.Y. 10036 • (212) 221-3300

Long Island Office
20 Crossways Park North, Suite 306
Woodbury, N.Y. 11797 • (516) 364-8130

New Jersey Office
666 Old Hook Road, Suite 17
Emerson, N.J. 07630 • (201) 261-2003

is quite indigent, with one-third of our disbursement recipients having incomes under $600 a month. It remains to be seen how many of these very poor patients will be helped by New Jersey's new "Medically Needy" program.

The largest single group of patients receiving financial disbursements from our New Jersey office are those over age 65 and on Medicare. Our disbursements to this group primarily help pay for home care for those ineligible for Medicare's home health services.

But, there are also many situations in which we are called upon to help augment the miniscule amount of home health care a very sick patient is getting via Medicare. We are finding that most of these patients - and all of them are in terminal stages of the illness or very close to it - are receiving home health aide services only 3 times a week, 2 hours per visit, upon discharge from the hospital. It should be emphasized here that these are patients deemed to need a skilled service such as nursing supervision. If they do not need a skilled service, they get nothing. Frequently this initial judgment is made by the discharge planner at the hospital who contacts the home health agency.

This is in sharp contrast to what used to be the norm: 4-hour visits, 4 or 5 times a week. One of our social workers, formerly with a New Jersey hospital as an oncology social worker, states that the more generous number of hours and visits could be depended upon in the past, but that today the picture is very different.

Another observation: Home health agencies are stating in advance just how long they will provide Medicare - reimbursed home health services. Ostensibly they make these predictions based on their experience with how long it usually takes patients with different types of cancer to stabilize sufficiently after discharge from the hospital so that they no longer need a skilled service. Our agency is apprised in advance so as to be ready to pick up with some financial help when the home health aide is withdrawn. These time predictions are definitely shorter than they used to be, although New Jersey's prospective hospital reimbursement system stimulates earlier hospital discharges.

Skilled nurses are no longer offering the kind of hands - on care in the home that they used to in the past. Since the home health aide is not allowed to perform skilled procedures which the nurse used to execute, the nurse teaches family members -- very quickly because time is short -- how to perform skilled procedures. This includes changing surgical dressings and giving intramuscular and subcutaneous injections for pain relief. Family members are also being relied on to flush surgically-placed Broviac and Hickman catheters which are used for chemotherapy and also to change urinary tract catheters and gastrostomy tubes.

In addition, skilled nursing supervision now seems to be limited to a 15-minute visit once a week. One can well wonder if this is indeed supervision. There is barely time to find out how comfortable the patient is, and whether the patient's pain is controlled. All this is happening when patients are being discharged earlier, needing more complicated procedures at home.

Another point raised by our social workers is related to the inadequacy of the 2-hour home health aide visit. What can she really accomplish in such a short time, especially when one must consider that she needs some time to attend to her own personal needs upon arriving at the home? Yes - there may be time to bathe the patient, perhaps prepare lunch, but what else?

We are also frequently called upon by hospices to cooperate with them in regard to Medicare hospice patients who have become "stabilized" and seem to be delaying the dying process. These patients may not be eligible for Medicare's typical home health services but, according to the referring hospice, they need help with home care. The irony of this kind of situation is quite obvious: why should home care be approvable if the patient is actively terminal but not when the patient still needs help but has extended the time of his/her projected demise?

Here is one example: Mrs. E.D. is an 82-year-old widow living with her 52-year old son who has a degenerative muscular disease. She has breast cancer metastatic to the lung with a prognosis of less than 6 months. Despite ongoing deterioration, she has surprised her doctors by surviving as long as she has. She has been on and off Medicare hospice benefits because of stabilizations in her condition.

She really requires 24 hour supervision. Medicare home health coverage was provided following a hospitalization for 2 hours a day, 5 days a week, but this was terminated after 4 weeks. Cancer Care is now helping her pay for 8 hours of help, 5 days a week.

Our New Jersey office is also dealing with many instances when the patient is eligible for Medicare hospice coverage but refuses to accept it because he/she still wants to fight the illness or because of other restrictions imposed by hospice. One such case is that of a 91-year-old man who has prostate cancer with metastases to the lungs and bone. His wife is 82 years old and not able to be of much help.

Medicare did supply a home health aide 2 hours 3 days a week for a short while, but pulled out as soon as it was determined that the patient was terminal and did not need a skilled service. Our social worker said that in the past a patient half as sick as this would have received help 5 times a week, 4 hours each day.

Clearly the experience of our social workers is that the amount of home health services has been cut back severely on an ongoing basis, and there is no longer such as thing as a crisis situation which might have been given special consideration.

The paltry amount of home health services which is currently being doled out is usually completely inadequate to the real need. It is as though it's based on a fixed formula, without any real regard for the patient's/family's circumstances.

Some of our elderly patients are living with children who work and others have very involved children. The fact that they must work does not seem to matter. This kind of approach on the part of Medicare will certainly lead to more instutionalization of parents by children who had tried to avoid it. Would this really be less costly for Medicare? Isn't all of this a short - sighted and punitive device to save money?

Mary K., for example, aged 76, lives with her 78-year-old husband who has diabetes. She has a recurrence of breast cancer with metastases to the lung and bones. She has been given a prognosis of less than 6 months, but the family will not consider hospice.

Her 2 children are actively involved in her care, but both go to work. Medicare terminated the part-time and intermittent home health services she was receiving. Cancer Care is now contributing to her care at home according to a plan worked out with the family.

Although we are not a Medicare-certified home health agency dealing directly with a fiscal intermediary, we hope that we have been able to provide telling evidence of the dismantling of Medicare's home health benefits. Cancer Care is trying to help needy elderly New Jerseyans and New Yorkers when Medicare denies them adequate home health care benefits. To our knowledge, this kind of assistance is unavailable in other areas.

We are extremely worried about the shrinkage of Medicare's home health benefit and what seems to presage the abandoment of homebound Medicare patients. To what extent the voluntary sector can compensate for this degree of cutback in the program is a critical issue. We hope that you will be able to persuade Congress and the Administration of the urgency of this issue.

Item 9

Home Care Council of New Jersey
The State Association of Homemaker-Home Health Aide Agencies
665 South Fullerton Ave. Montclair New Jersey 07042 (201) 744-5524

Presented by Kenneth Dolan, Executive Director
before a Special U.S. Senate Hearing sponsored by
U.S. Senator Bill Bradley

Home Care Council of New Jersey

Testimony On

Medicare Home Health Service Cuts

The Home Care Council of New Jersey is the exclusive representative of the state network of non-profit homemaker-home health aide agencies. Last year the Council's 22 member agencies provided over 3.5 million hours of homemaker-home health aide services to some 25,000 frail elderly and disabled New Jersey residents. It is a documented fact that of all home health care services, homemaker-home health aide service is the most important and necessary in reducing hospital stays and avoiding inappropriate long-term institutionalization.

Over the past four years our member agencies have experienced significant reductions in home health aide services funded through Medicare. These service reductions began in 1981, when the Health Care Financing Administration issued new regulations redefining service parameters for home health aide services.

Last July, the Council conducted a survey of member agencies to determine the actual amount of home health aide service being authorized by Medicare. The results were distressing. On a statewide basis, the breakdown of Medicare patients receiving home health aide service was as follows:

- 46.46% of the patients received six hours or less of home health aide service per week;
- 41.36% of the patients received between seven and eleven hours of home health aide service per week;
- 11.98% of the patients received 12 hours or more of home health aide service per week.

(continued)

Members: Atlantic County Homemaker — Home Health Aide Service • Visiting Homemaker-Home Health Aide Service of Bergen County • Visiting Homemaker and Health Services (Burlington County) • Jersey Cape Visiting Homemaker Service • Cumberland County Homemaker — Home Health Aide Service • CMR-ILL Service (Essex County) • Visiting Homemaker-Home Health Aide Service of Gloucester County • Visiting Homemaker Service of Hudson County • Visiting Homemaker Service of Hunterdon County • Princeton Community Homemaker — Home Health Aide Service • Visiting Homemaker-Home Health Aide Service of Middlesex County • Visiting Homemaker-Home Health Aide Service of Monmouth County • Visiting Homemaker Service of Morris County • Visiting Homemaker Service of Ocean County • Visiting Homemaker Service of Passaic County • Visiting Homemaker-Home Health Aide Service of Salem County • Visiting Homemaker Service of Somerset County • Visiting Homemaker Service of Sussex County • Visiting Homemaker Service of Central Union County • SAGE (Union County) • Visiting Homemaker Service of Warren County

Testimony of Kenneth Dolan
April 21, 1986

This data graphically demonstrates that restrictive Medicare policies have dramatically reduced the availability of needed home care services. This service reduction is particulary disturbing when one considers the fact that the overwhelming majority of Medicare patients receiving home health aide services are frail elderly -- usually 75 years old or older -- who have recently been discharged from the hospital while still in the early stages of recovery from major acute illnesses. The fact that almost 50% of these patients are receiving less than one hour of home health aide service per day clearly demonstrates the cruelty and inhumanity of current Medicare policies.

The Council urges Congress to launch a major investigation of what amounts to the Medicare Programs total abrogration of responsibility to our Nation's frail elderly and disabled.

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